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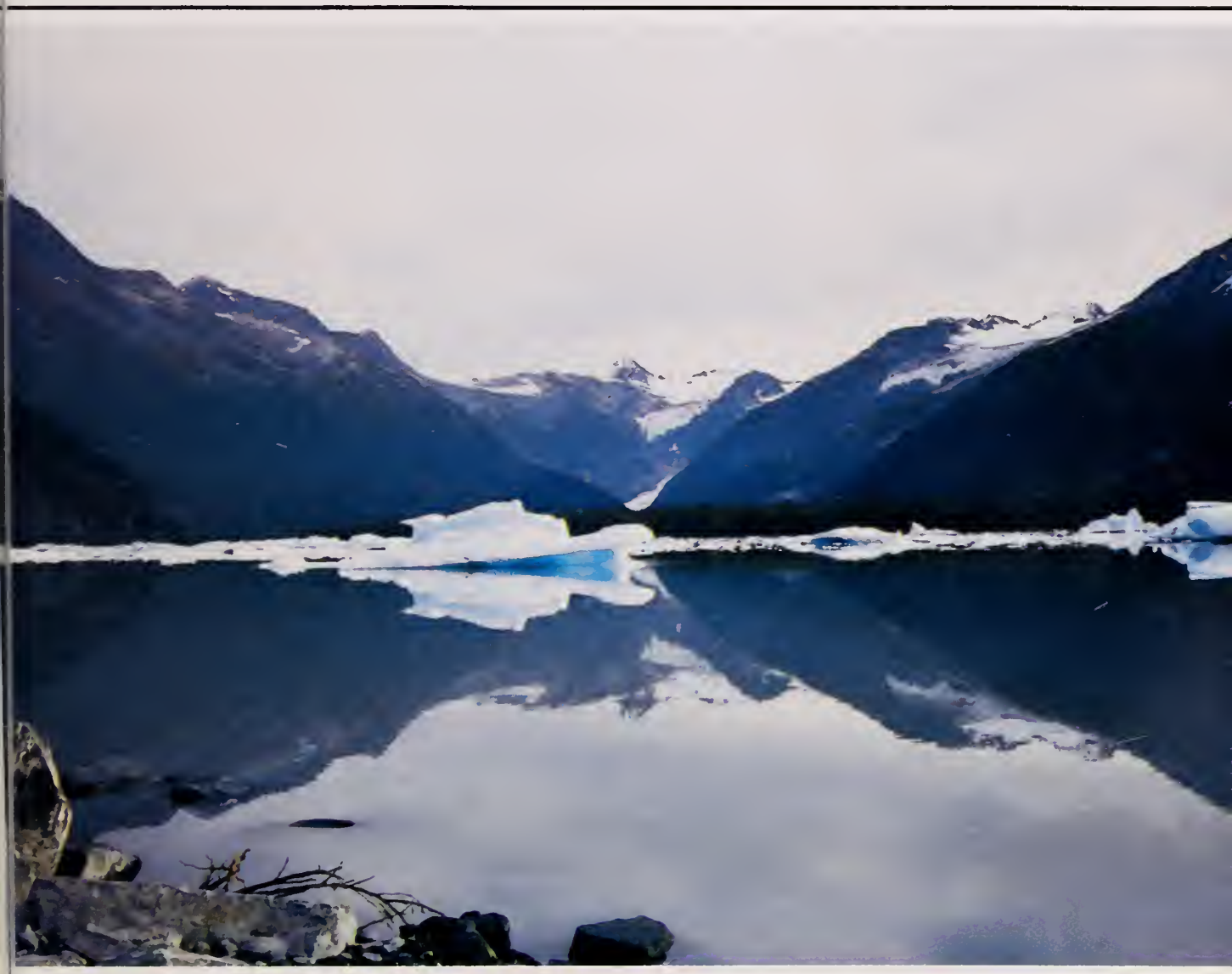
Nebraska Medical Journal



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AMA NEWS NOTES

UNIVERSAL COVERAGE SUPPORT INTACT AMA TELLS CLINTON IN LETTER

The AMA has not changed its aggressive support for universal coverage, the Association said in a letter to President Clinton.

The Association has expanded policy, the letter said, to support integrating other approaches, such as an individual mandate and health IRAs as well as an employer requirement, to achieve universal coverage.

"We believe that this expanded policy base — which should not be construed as 'backing off' employer-required insurance — is more flexible than our earlier position," the AMA said.

The expanded policy reflects its commitment "to comprehensive health system reform that provides coverage for all Americans all the time," said AMA Board Chair Lonnie R. Bristow, MD.

At its 1993 Interim Meeting In New Orleans, the AMA's House of Delegates concluded that universal coverage can best be realized by including individual-required and individually owned insurance along with employer-required coverage.

Since 1989, the Association has supported the same type of employer-required coverage called for in Clinton's health system reform plan.

"What we have done is expand our support for more methods to pay for universal coverage," said Dr. Bristow.

"We are very amenable to looking at different proposals as long as they get to the goal of universal coverage."

He added, "The AMA agrees with Mrs. Clinton, who said that individually required coverage, as in Sen. Chafee's proposal, may be an additional way to achieve universal coverage."

Sen. John Chaffee (R, R.I.) presented a system reform proposal to Congress that supports an individual funding approach.

Dr. Bristow urged all players, public and private, to be constructive and nonpartisan.

"Our mutual objective must remain achieving national consensus that will be necessary before we can guarantee the health care security of all Americans.

"We are pledged to working with the administration, Congress, the health care industry and the American people to make sure that occurs."

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AMA NEWS NOTES

SIGNIFICANT DIFFERENCES RELATED ON CLINTON PLAN

Significant differences remain between the AMA and the White House on proposals to reform the nation's health system, the Association said in a letter to President Clinton.

"The AMA and the administration share common goals in our proposals for health system reform," wrote James S. Todd, MD, the Association's executive vice president. "We have, however, significant disagreements with other aspects of the Health Security Act."

In the letter, the AMA requested a meeting with the president before Congress reconvenes. It also spelled out the common reform goals between Clinton and the Association — universal coverage, community rating, portability, administrative simplicity and freedom of choice.

Support for universal coverage remains intact, Dr. Todd wrote. Recent AMA action expanding policy to include both individual and employer funding approaches provides "new avenues toward achieving universal coverage."

The AMA also outlined aspects of the administration's proposal the AMA seeks to change — aspects that represent "our three greatest disappointments with your plan," Dr. Todd wrote.

Clinton's reform plan relies too heavily on governmental regulation, Dr. Todd wrote, pointing to the plan's excessive use of state alliances, a national health board and price controls.

The proposal also fails to protect medical decision-making by physicians from giant insurance companies, hospital networks and aggressive for-profit health care corporations.

"In such an environment, the type of antitrust and negotiations protections discussed on numerous occasions with the administration need to be incorporated into any final reform package," Dr. Todd said.

Clinton's plan also lacks meaningful liability reform, Dr. Todd said, adding that successful tort reform must include a $250,000 cap on noneconomic, nonmedical damages.

"Physicians will be unable to act as efficiently as they must — the incentives will not have changed — as long as comprehensive tort reform is not addressed."

No physician group, Dr. Todd concluded, will support budget enforcement provisions or the authority of the alliances proposed in the Clinton plan.

"All groups seek a larger, guaranteed physician professional society role in a reformed system."

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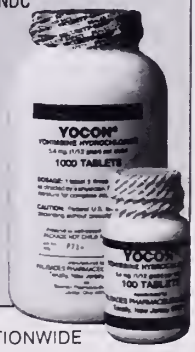

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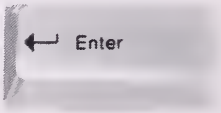

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PRESIDENT'S PAGE

Compensating Physicians - A Business or Moral Choice?

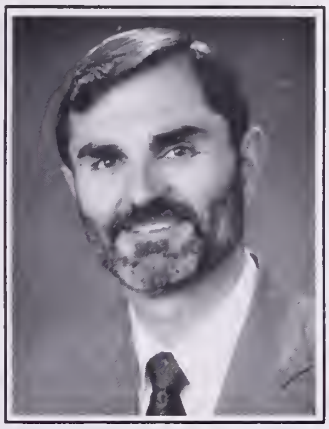
ROBERT F. SHAPIRO, M.D.

Our beliefs are important; they govern our choices. They define our boundaries for what is acceptable and unacceptable. For many physicians, the way they are compensated: salary, capitation, or fee-for-service, taps into their beliefs. This President's Page discusses several methods to pay physicians and why and who might favor each.

Why is the method of compensating physicians receiving more attention? As we are acutely aware, our world of medical practice is changing rapidly. One emerging trend is physicians joining together into larger groups to achieve economies of scale which will allow them to compete more effectively. As we view our futures, we know there is a strong possibility that, if we aren't in one already, we could find ourselves practicing in organizations controlled by physicians, by hospitals, by insurance companies, or by combinations of the above; all of which will be in competition, bidding and negotiating the terms upon which we will provide services to patients. Appropriately compensating physicians in these groups is integral to survival and prosperity for both physicians and plans.

To participate in this process, physicians have acquired, will acquire, or will employ trained business people with the skills to help them adapt and cope with this new environment. It is unlikely we will independently set fees for our services and expect patients to pay in full, when payments from their "insurers" or "plans" cover less than the full amount, after deductibles and co-insurance are considered. It doesn't appear the indemnity concept, common to automobile insurance, will prevail in health care even though some feel that it should.

Paying physicians in this more competitive and structured environment presents problems and opportunities. For plans and participating groups to be competitive, costs need to be predictable, physicians need motivation to be productive, and quality must be maintained and even enhanced.



Robert F. Shapiro, M.D.

With this framework, is compensating physicians strictly a business decision? Does it include a moral and ethical dimension? Where does it fit? How do the methods measure up from these perspectives?

Salary begins the discussion. From a business standpoint, salary, benefits, and possibly an incentive bonus is easy to use. The AMA and organizations such as the Medical Group Management Association make available a wealth of data on earnings for different physician specialties, payment methodologies, and geographic locations. Even though the data is a composite of all methods, it is still useful in determining what salary levels must be paid.

Using salary, physician costs are fixed costs. Although fixed costs are paid even when doctors are not busy, they are predictable when determining costs of physician services for a defined patient population. By analyzing demographic data to ensure that a plan has an adequate number and mix of physicians, the physicians costs for the year are known. This knowledge helps plan administrators bid more competitively on contracts. If the plan does well, whatever bonus incentive has been incorporated can be implemented; plan administrators would be happy to be in that position.

Why would physicians prefer salary? Many

physicians under the age of 40 are electing salaries and a significant number of physicians over age 55 are doing so also. Many physicians are not interested in practice business and do not want those concerns, but may not be interested in the military or Veterans Administration.

Other physicians do not want the expense of a capital investment in their own practice nor to incur the expense of buying into an existing practice. For younger physicians with significant educational debt, the wish to purchase a home, and a high titer of anxiety about their ability to repay debt, the security of a salary, a significant package of benefits, regular hours and guaranteed timeoff become attractive features. That the patients may not really be their patients and therefore job loss also means loss of practice doesn't seem to be a constraint. We are living in a mobile society and the able physician finds another job quickly and easily.

In terms of medical practice, some believe salary plus incentive bonus has the right mix of incentives and fewer perverse incentives. There is little need to order too many tests or do extra procedures because no extra income is received for doing them.

On the other hand, one might perceive perverse incentives not to work hard. Seeing as few patients as possible and making sure that one is "out the door" at the appointed time are examples. This explains the value of an incentive bonus to reward physicians for high productivity. Financial risk for the physician is also not significant.

Capitation reimbursement for physicians can take many forms. Capitation has more variability than salary for both payer and physician, but capitation "fixes the cost" per patient and has advantages similar to salary for budgeting. Since capitation puts the physician at risk for agreed upon services and is only paid for the number of patients specified, it transfers risk to the physician for both services rendered and volume of patients seen. Key to your participation in capitation is control over your costs to provide service and it helps to track the value of these services compared to your fees to monitor how you are doing.

In one variation, one might be partially capitated for a specified spectrum of services and reimbursed fee-for-service for other services. In another, one might be expected to pay for specialist services and in some cases even hospital services are paid from the capitated amount.

Capitating service creates an incentive to maximize the number of patients covered because revenues are a function of the patient numbers. A major concern with this payment method is that dependent on which additional costs must be paid from the capitation amount, there could be strong incentives not to obtain consultation when needed, or to decide that a lab test or x-ray is not needed. Review is expected to monitor under utilization.

Although initially perceived as a method to reimburse primary care physicians, capitation is now being extended to specialists. The Cedars Sinai Physicians Association in Los Angeles is one example. In this model, the approach is called subcapitation, and is handled like capitation. Specialists must take the same measures as primary care doctors to determine whether the system works for them.

For many years and many of us, fee-for-service has been the payment method of choice. The fee-for-service model has vocal supporters and detractors. When fees are set rationally, (Development of the RBRVS system, with all its imperfections, has introduced a level of service comparability into the system and makes setting fees less arbitrary but less like a free market), the system provides fair compensation, is related to services performed, and allows physicians more control over their own destiny, because it directly correlates work with reward.

There are physicians who feel that fee-for-service is the only moral way to be compensated. The basis for their belief is that if fee-for-service creates a tendency to "do too much" that doing so is better for the patient than the converse, where too little is done. This belief equates the extra expense with essential care, which might not have been provided.

It is acknowledged that medical liability concerns generate extra costs in a fee-for-service system (but do in other systems as well), and is responsible for some "doing too much". It is difficult to explain why one didn't get that one test or study which would have revealed the unusual diagnosis and the incentive is there to do it.

Unfortunately, there are studies which show fee-for-service also has perverse incentives. The "Hanlester" case in California involved doctors who made small interests in "sham" clinical laboratories which then paid them big returns

on these investments. Florida cost commission studies showed higher charges and larger volumes where physicians owned interests in laboratories, CAT scanners, MRIs, ultrasound machines, and pharmacies. Medicaid mills in large inner cities billed for services not provided and embarrassed our profession.

Last to be discussed is discounting fee for service for a plan like a PPO. The intent of plan contractors is to provide the physician with an increased number of patients in return for the discount from his/her normal fee. If the physician can control practice costs, increased cash flow from additional patients will offset discounts and even generate additional earnings. When this approach works, a physician would likely oppose "willing provider" legislation favored by other physicians fearing loss of these patients and who would, therefore, have been willing to provide the contractor with the services for the same fees.

From a regulator's standpoint, a problem created by discounted fee-for-service is determining whether more competition is promoted by letting all willing physicians participate or whether doing so increases costs, since allowing all physicians to participate reduces the value of discounting because fewer new patients are likely to be generated. Which prevails; choice of physician or cost containment?

Is there an answer? Unfortunately, there are no easy answers. As we review each method, I think we would conclude no one approach holds a claim to paramount virtue. No method satisfies all preferences. Proponents and opponents of each method recount anecdotal horror stories of excesses no matter how reimbursement is structured.

Your choice and level of comfort with any method of reimbursement will need to reflect your values and is a business decision. The medical association represents physicians paid for their services in many ways.

Your moral or ethical consideration relates to we physicians as professionals. Although there are several definitions of a professional, one which I find conceptually useful is a professional is an individual who, when providing services he/she is trained to provide, puts the interest of the client or patient ahead of his/her self interest. (Although there are honest, ethical business people who follow moral and ethical rules; they are not bound to this rule.)

What this means, operationally, is that in whatever situation the physician finds him/herself, the expectation is that whatever is done is that which is most appropriate for the patient under the circumstances. If we keep that in mind, then we will be able to practice medicine, serve as advocates for our patients regardless of the method of payment, and be able to look anyone in the eye and say that the payment method *"macht nichts"* (doesn't matter).

ORIGINAL ARTICLE

Helping The Elderly Stay Active: A technique for detecting disability in the primary care office

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ABSTRACT:

The inability to perform essential activities of daily living such as cooking, shopping, dressing and bathing is termed functional disability. These deficits can prevent elders from enjoying independent, active lifestyles. The development of functional disability is a gradual process. Early identification and intervention by the primary care physician can often reduce functional decline. Screening for functional decline has traditionally been performed by either questionnaire or direct observation of tasks. This paper reviews methods which have been proposed to integrate functional disability screening into office practice. A method which incorporates both questionnaire and direct observation is recommended by the authors. The method of screening proposed targets specific areas prone to dysfunction. It focuses on simple screens of vision, hearing, arm and leg function, urinary incontinence, mental status, depression, nutrition, activities of daily living, environmental hazards, and social support systems. Appropriate methods of follow up evaluation and treatment are provided. This fifteen minute technique is a practical and applicable means of screening elderly patients for functional deficits in the primary care office.

INTRODUCTION

THE ability to perform the essential activities of everyday life, such as cooking, shopping, dressing and bathing is taken for granted by healthy adults. These basic functions, however, are major obstacles for many older people. The inability to accomplish these activities is termed functional disability.

Functional disabilities are more important in the everyday lives of older persons than their underlying diseases. Medical practice and training has been slow to appreciate this situation. Modern medicine developed in an era when acute illness was the leading cause of death. During the last half of this century, chronic illness has become the leading cause of both death and disability. People are living longer and more of the later years are being lived with disabling conditions. Clearly the challenge to medicine now and in the future will be to identify, prevent and treat disability.

Disabilities develop gradually and a window of opportunity exists for detecting problems and intervening to prevent or reduce functional decline. How and what one should detect has been a subject of debate and study. Increasingly, it is clear that detection will need to be provided in the primary care physician's office where most older persons receive health care.

This paper reviews methods which have been proposed for integrating functional disability screening into office practice. One of these methods is recommended by the authors and discussed in detail. The basic assumptions underlying this recommendation are that the method should not greatly lengthen the office visit and that when problems are detected there are actions that can be taken to help the patient.

WHY AND HOW TO SCREEN

Routine screening uncovers mild problems that would otherwise be overlooked. Studies show that while physicians are good at detecting severe deficits, mild or moderate difficulties are often missed.[1]

Several methods of functional assessment have been proposed for use by the primary care physician. For the most part, these are based on expert opinion and none have been rigorously tested. None-the-less the problems of functional disability are so pressing that it is generally felt that applying current state of the art measures is justified. The methods that have been proposed for use employ two main modes of information gathering: the questionnaire and direct observation. Questionnaires are relatively rapid to use and many can be self-administered prior to the

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physician visit. The disadvantage to questionnaires is that elderly patients often under-report their functional disabilities, while family members tend to over-report the elder's disabilities.[2] Direct observation of a task, as used in a performance based evaluation, provides a more objective measure of a patient's abilities. This method is not without its disadvantages. Performance based assessment has traditionally been more time consuming, often requires specialized props and specific training may be needed for proper administration. A screening tool which incorporates both methods would theoretically have the advantages of rapid administration and verification of abilities and disabilities by direct observation.

The Society of General Internal Medicine's (SGIM) Task Force on Health Assessment[3] suggests that specific indicators of functional status such as general appearance, speech pattern, mood, handgrip, use of assistive devices, and gait should be emphasized in the history and physical exam. This directed history and physical can be combined with functional status questionnaires to improve identification of functional disabilities. The task force suggests administration of Instrumental Activities of Daily Living (IADL) and Geriatric Depression Scale (GDS) in all home-dwelling individuals over the age of 65 at least once very three years. In these questionnaires the IADL measures limitation in the ability to shop, cook and care for finances, while the GDS is a screening tool for depression in the elderly. For those individuals considered more frail, (aged 75 and older and those older than 65 living in a nursing home) an evaluation with Katz Activities of Daily Living (ADL) and the Folstein mini-mental state exam[3] is also recommended. The ADL questionnaire assesses the basic functional abilities of bathing, eating, and dressing. The Folstein mental state exam screens for deficits in orientation, registration, attention, calculation, and language. In appreciation of practitioner's time constraints, performance based assessments were not recommended. A major drawback to the SGIM recommendations is the fact that there is no discussion of how one is to interpret the results of these screens. Likewise, specific follow-up interventions for problems that are detected are not discussed.

Miller et al. tested the usefulness of functional screening instruments in an outpatient general medicine clinic of a Californian Veterans Administration Hospital. Trained geriatric nurses and physician's assistants administered mental state exams, geriatric depression scales, and observed patients perform the Tinetti gait and balance evaluation. The patients were weighed and had midarm circumference measured. A chart review provided the most recent results of albumin, creatinine, blood urea nitrogen and hematocrit tests. The estimated time for this process was 20-30 minutes. He found that although this method was very effective at identifying functional deficits, many physicians did not have an effective means for follow-up evaluation and treatment of these problems.[4]

Unless there is appropriate follow-up evaluation and treatment after functional screening one cannot expect to improve outcome. Acknowledging this point, a task force for the American College of Physicians Subcommittee on Aging developed a series of recommendations to identify functional disability in elderly patients and provided steps to follow up abnormal results. These recommendations are to be incorporated into the patient's general examination and in some cases can be substituted for other commonly done parts of the examination. Little, if any, time is added to the history and physical. Much of the evaluation relies on performance, rather than self report. This screen focuses on target areas which define frequently encountered problems that, when identified, have well defined evaluation and treatment interventions. Target areas of assessment discussed here are also mentioned by Pannill[5], Rubenstein[3], Miller[4] and Morris[6] in their office based functional assessment screens. These areas include: vision, hearing, arm function, leg function, urinary incontinence, nutrition, mental status, depression, activities of daily living/ instrumental activities of daily living, environmental safety and social support.[7]

TARGET AREAS FOR FUNCTIONAL SCREENING

The rationale behind testing each target area, a description of the testing procedure and appropriate follow-up of positive results are discussed below and summarized in table 1. That table is designed so that it can be clipped and replicated for use by the physician.

VISION

Up to 44% of elderly persons have a functionally significant decrease in visual acuity.[8] These individuals are at increased risk for falls and injuries.[9] Once identified, however, many individuals may be helped with corrective lenses or surgery. Visual acuity can be reliably screened with the use of a Jaeger card. This card is held 14" from the patient. If the patient uses correc-

tive lenses these should be worn during the exam. If the patient is unable to read better than 20/40 a referral should be made to an ophthalmologist.[7] For most older patients this screen is a better use of the practitioner's time than is the fundoscopic exam.

HEARING

The prevalence of hearing impairment for people aged 65-74 is 24% and is 39% for those over 75 years of age. The most common type of hearing loss in the elderly is bilateral high frequency hearing loss. Affected individuals often have difficulty distinguishing many of the consonants used in daily conversations. The difficulty in communication caused by hearing impairment can lead to social isolation, suspiciousness and depression.[10] Hearing impairment is also linked to memory disorders. Screening for hearing loss can be performed at the bedside by means of the whisper test.[11] In this test the examiner stands out of sight of the patient, two feet from the tested ear, exhales fully and whispers an easily answered question. The examiner masks the hearing in the non-tested ear by gently occluding and rubbing the external auditory canal. If the patient is unable to answer the question the auditory canals are examined for cerumen. If no cerumen is present the patient should have audiometric testing to determine if amplification would be beneficial.[7] If the patient is unable or unwilling to purchase hearing aides, assistive listening devices are an effective but less expensive option for amplification. These devices are composed of a microphone and amplifying headset and can be purchased at radio supply stores.

ARM FUNCTION

A British study of home dwelling Londoners greater than 85 years of age found that between 13-25% of these individuals were unable to open jars, carry sauce pans or make a cup of tea.[12] Problems with arm function can be divided into proximal and distal deficits. Proximal arm function testing evaluates shoulder and elbow range of motion, shoulder muscle strength and to some degree biceps strength. Proximal arm function testing is designed to identify those individuals with difficulty carrying objects, styling their hair and performing upper body dressing. Screening for proximal arm function is done by asking the patient to touch the back of his/her head with both hands. Distal arm function assesses for disabilities in fine motor coordination and finger strength. Distal function relates to the ability to write and to utilize eating utensils. This function can be tested by observing the patient pick up a pencil. If the patient is unable to perform the arm function screening exams, then full evaluation of the joints, muscles and sensation of the limb should be done in search of treatable disorders.[7] If permanent muscle weakness or deformity contribute to the patient's arm dysfunction the patient may benefit from an evaluation by an occupational therapist. The occupational therapist can choose appropriate assistive devices and instruct the person in their use. Use of assistive devices such as double handled pots, sock donners, and enlarged water tap handles can greatly improve functional independence.[12]

LEG FUNCTION

Gait instability and falls in the elderly are associated with significant morbidity, mortality and can lead to premature nursing home placement.[6] Walking is a highly integrated process requiring complementary function of cognitive, neural, muscular and skeletal components. Disruption in any of these areas can result in instability and falls. Up to 30% of community dwelling elderly fall each year.[13] One half of all elderly fallers admit to being afraid of falling and 25% restrict basic activities because of this fear.[14] Assessment of leg function can be made by performing the "Get up and Go" test.[7,15] The patient is asked to rise from a chair, walk 10 feet, turn around, return to his seat and sit down. This process assesses proximal muscle strength, knee and hip function, postural stability, stability on turning and safety with sitting. If the patient is unable to perform this screen a full evaluation of neuromuscular function of the legs should be performed. A physical therapist can be helpful in choosing appropriate assistive devices such as canes, walkers, raised toilet seats or riser chairs. Many patients will also benefit from gait and balance training programs.

INCONTINENCE

Urinary incontinence is a problem for at least 20% of community dwelling elderly and 50% of nursing home residents.[16,17] It is associated with both financial and psychological expenses. Many elderly feel that incontinence is a normal part of aging and are reluctant to bring up the issue during routine visits with their physicians. A study of a screening program for the elderly by New Zealander general practitioners revealed that although 7.4% of the subjects reported incontinence, only 3.9% of these individuals were known by their physicians to have this problem.[8] The simple question "Do you ever

lose urine and get wet" is a nonjudgmental means of addressing this sensitive problem.[7] If the patient indicates they have been incontinent, further questioning should determine the duration and frequency of incontinence as well as the amount of urine lost with each accident. Kane et al. developed the mnemonic DRIP to help physicians remember the reversible causes for incontinence. These are: D-delirium; R-restricted mobility, urinary retention; I-infection, inflammation (i.e. atrophic vaginitis), impaction (fecal); P-polyuria (hyperglycemia, CHF), pharmaceutical (diuretics, anticholinergics, psychoactive agents.)[17] Approximately 80% of individuals with urinary incontinence can be improved with intervention. If initial interventions are unsuccessful in treating incontinence, referral to a urologist or incontinence clinic may be indicated.

NUTRITION

Poor nutritional status often accompanies chronic illness and disability. It is often insidious in onset. Malnutrition is associated with increased morbidity and mortality. In screening for nutritional risk the patient's height and weight should be obtained. If the patient responds "yes" to the question "Have you lost more than 10 lbs. in the past year?"[7], then an in-depth nutritional history should be taken. If the cause of weight loss appears to be inadequate intake, evaluation for ill fitting dentures, dysphagia, or depression should be considered. High protein supplements can be helpful interventions to deliver proper nutrition support in some individuals. Occasionally, relatives must be contacted for their assistance in providing meals. In the absence of friends or relatives, a referral to the local Area Agency on Aging will result in interventions to deliver proper nutritional support. If the nutritional history does not reveal an obvious cause of weight loss the patient should be screened for occult malignancy or metabolic derangements such as diabetes and thyroid disease.

MENTAL STATUS

While the prevalence of dementia is only 3-5% at age 65, it may be as high as 47% by age 85.[18] Many mildly cognitively impaired individuals retain their social skills thus allowing them to hide their deficits quite effectively.[19] In fact physicians miss this condition in 40% to 80% of cases.[1,19] Many physicians rely on orientation as a screen for cognitive deficits. Although orientation is a specific means for detecting cognitive deficits it is fair from sensitive. Short term memory and ability to perform calculations are more sensitive indicators of impaired cognition.[20] The ability to perform calculations, however, is affected by educational background. Thus, short term memory is recommended as a reliable and specific simple screen for cognitive deficits. The patient is asked to recall a list of three objects immediately after presentation and again at three minutes.[7] We use Apple, Table, and Penny but any simple words could be used. If the patient is unable to recall all three items, then the Folstein Mini-Mental State Exam[21] should be administered. The Mini-Mental exam should also be administered to any individual who complains of memory problems, as well as to individuals whose families have noted cognitive decline. A score of less than 24 suggests the presence of a problem with cognition. In this situation, further history as to the onset, duration and fluctuation of symptoms should be obtained. History and physical exam should emphasize review of current medications, complete neurological evaluation, and laboratory testing to look for reversible causes of dementia.

ACTIVITIES OF DAILY LIVING

Activities of Daily Living (ADL) reflect an individual's ability to perform basic functions independently. The Katz index of ADL[22] includes bathing, dressing, toileting and transferring from bed to chair, in addition to continence and feeding. Instrumental Activities of Daily Living (IADL)[23] include telephone use, meal preparation, shopping, and money management. Ability to function for self-maintenance is not specifically related to the number or type of physical illnesses. Many individuals with significant health problems are not disabled. Even patients with mild to moderate cognitive deficits may be able to function well in familiar surroundings of their own homes. Measurement of ADLs and IADLs can provide a more clear understanding of a patient's functioning in his/her current environment. Persons able to do all of their IADLs have less than half the death rate of all persons their age while persons unable to do any IADLs are five times more likely to die.[24] Screening for problems with ADLs and IADLs is done by asking the patient "Can you get out of bed by yourself?", "Can you dress yourself?" "Can you make your own meals?" and "Can you do your own shopping?". Identification of individuals with problems with self-cares can lead to appropriate referral to home nursing agencies, or programs such as senior meal sites or meals on wheels. Neighbors,

church groups, and extended family networks are often willing to provide assistance with these activities in communities where formal services are unavailable. Occupational therapists are skillful at determining which assistive devices such as shower chairs, grab bars, modified eating utensils, etc. could be used to improve independence.

DEPRESSION

Elderly individuals often develop dysphoria when dealing with the everyday realities of chronic illness. This dysphoria can interfere with social functioning and ability to perform basic self cares. At worst the depressed elder can be labeled as demented because of profound apathy. The symptoms of depression often go unrecognized in the elderly. When compared to younger people with depression, elders describe more problems with weight loss and constipation and have fewer suicidal thoughts.[25] Many also are overly focused on bodily concern and make frequent visits to the office with multiple complaints. Once recognized, the elderly patient with depression usually responds to low doses of antidepressant medication. Treatment of depression is associated with increased life expectancy (especially in men), improved social relationships and presumably improved quality of life.[26] The question "Do you often feel sad or depressed?" can help identify patients at risk for depression. Emphasizing often in the question helps to exclude persons with unhappiness but not true depression. Persons answering "yes" should be further tested by having the patient complete a 30 item Geriatric Depression Scale.[27] A score of 14 or higher is good evidence for a clinically significant depression. Once persons with depression are identified, appropriate treatment with low dose of antidepressant medications of counselling should be initiated by the primary care physician or a consulting psychiatrist.

HOME ENVIRONMENT

Environmental hazards in the home are associated with increased risk for falling. The likelihood for injury and death from falls increases with age. One percent of reported falls in those over age 65 are associated with hip fractures.[14] Stairs are often cited as the location of falls. Inadequate differentiation of stair edges, poor lighting and decreased visual acuity all contribute to difficulty managing stairs. Throw rugs, electrical cords, and peeling floor tiles all represent hazards which can increase risk for falls in elders with short step height.[28] To identify potential hazards the patient should be asked about trouble managing stairs, presence of throw rugs in the home, adequacy of lighting inside and outside the home, as well as presence or absence of safety equipment such as grab bars in the bathroom. Elderly are also at greater risk for suffering burn accidents in the home. Loose sleeves of gowns can easily ignite when close to gas range burners. The average temperature of a water heater is 140 to 160 degrees fahrenheit. Contact with water at this temperature can produce a full-thickness burn in 10 seconds.[29] Delayed reaction time and increased incidence of peripheral neuropathy place elders at risk for prolonged exposure to excess heat, resulting in serious burns. If any of these areas are a problem, a full home safety inventory should be completed. An occupational therapist can perform a home safety evaluation to look for trouble spots. Medicare will usually pay for a physician authorized home visit to evaluate home safety.

SOCIAL SUPPORT

The amount of social support an individual enjoys is difficult to measure. Elders with a strong network of family and friends who are available for caregiving are less reliant on more formal support systems. Conversely those individuals with strained informal support systems can benefit from formal services such as home health aides, nurses, and community agencies for the aged. It is important to identify individuals without informal support systems so they may be offered services that can improve their chances for community living. These elders can be identified by asking "Is there someone who would give you help if you were sick or disabled?"

When assessing social support systems, it is also important to discuss surrogate decision makers. Recent legislation (The Federal Self Determination Act) mandates hospitals, home health agencies, and health maintenance organizations to address the issue of advanced directives and to provide information regarding advanced directives to all individuals entering these institutions. The Self Determination Act does not, however, require the inquiry of patients' desires in non-HMO outpatient settings. Intuitively the non-threatening office of the primary care physician provides the most conducive environment for discussion of advanced directives. A study of patients attitudes on Advanced Directives revealed that 93 percent of patients desired either a conversation with

their physician on the subject of advanced directives, a living will, or a durable power of attorney. Although 57 percent of patients wanted to document their desires for future care, only 7 percent had done so. Patients cited lack of physician initiative in addressing the subject as a major barrier in executing advanced directives. The sensitivity of the topic was only rarely described by patients as a barrier to issuing an advanced directive.[30] These barriers can be overcome by addressing the issue of advanced directives with the patient. The question "Who would be able to make health decisions for you if you were unable to make them yourself?" opens the door to discussion of this sensitive topic.

CONCLUSION

Functional screening can be incorporated in the initial office visit and yearly physical exams by using the simple questions and performance based exams discussed. It can be easily incorporated into the general exam without increasing the time for the office visit. For example, visual and auditory screening with the methods described here can be substituted for the ophthalmoscopic and auditory canal exams. In our Well Elderly Clinic the functional screen is administered by a nurse prior to the physician evaluation. Problem areas are noted and further follow-up is undertaken during the history and physical exam. The functional screen requires approximately fifteen minutes for completion. If more than one to two areas of difficulty are discovered, future appointments are made for further evaluation. We have found this screen very effective in detecting previously undiagnosed functional disabilities which benefit from therapeutic interventions. The form used in the clinic is included as Table 1.

TABLE 1
Functional Disability Screening

TARGET AREAS	FURTHER EVALUATION
VISION JAEGER CARD SCORE RT. EYE_____ LT. EYE_____	LESS THAN 20/40 OPHTHO. REFERRAL
HEARING WHISPER TEST RT. EAR_____ LT. EAR_____ CHECK FOR WAX RT. EAR_____ LT. EAR_____ USE OF AIDE RT. EAR_____ LT. EAR_____	If impaired: AUDIOLOGY REFERRAL
ARM FUNCTION PROXIMAL-TOUCH BACK OF HEAD WITH BOTH HANDS _____ DISTAL-PICK UP PENCIL WITH EACH HAND & PUT IT BACK_____	If Unable: NEUROMUSCULAR EXAM PAIN/EDEMA/WEAKNESS? OT REFERRAL
LEG FUNCTION RISE FROM CHAIR _____ WALK TEN FEET _____ TURN AND SIT DOWN _____	If Unable: NEUROMUSCULAR EXAM PAIN/EDEMA/WEAKNESS? PT REFERRAL
MENTAL STATUS I'M GOING TO NAME THREE OBJECTS. I'LL ASK YOU TO REPEAT THEM NOW AND IN A FEW MINUTES. APPLE_____ TABLE_____ PENNY_____ IF UNABLE TO RECALL AT 3 MINUTES, THEN MINI-MENTAL STATE EXAM (MMSE)	MMSE LESS THAN 24 DIRECTED H&P MEDICATION REVIEW LAB: CBC, B12, THYROID & CHEM PROFILES, HEAD CT
DEPRESSION DO YOU OFTEN FEEL SAD OR DEPRESSED?_____ IF YES: GERIATRIC DEPRESSION SCALE (GDS)_____	GDS GREATER THAN 5 MEDICATION REVIEW LAB: THYROID PROFILE CALCIUM, ANTI-DEPRESSANT VS. PSYCH REFERRAL
HOME ENVIRONMENT HAVE YOU HAD ANY FALLS AT HOME? _____ # OF STAIRS?_____ THROW RUGS?_____ BATH RAILS?_____ GAS STOVE?_____	If Concerns: SAFETY INVENTORY OT HOME EVALUATION
ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE ARE YOU ABLE TO: GET OUT OF BED?_____ DRESS?_____ PREPARE MEALS?_____ SHOP?_____	If Unable: OT EVALUATION
INCONTINENCE DO YOU EVER LOSE YOUR URINE AND GET WET? _____ IF YES: FREQUENCY_____ AMOUNT_____ TIME_____ SITUATION_____	VOIDING RECORD URINALYSIS CHECK CAUSES "DRIP"
NUTRITION HAVE YOU LOST 10 LBS OR MORE IN THE PAST YEAR?_____ AMT._____ CURRENT WT._____ HT._____	NUTRITIONAL HISTORY: ADEQUATE-WEIGHT LOSS EVALUATION; INADEQUATE-AREA AGY ON AGING REFERRAL
SOCIAL SUPPORT IS THERE SOMEONE WHO WOULD GIVE YOU HELP IF YOU WERE SICK OR DISABLED? _____ WHO?_____ WHO WOULD BE ABLE TO MAKE HEALTH DECISIONS FOR YOU IF YOU WERE UNABLE TO MAKE THEM YOURSELF?_____	REFERRAL TO: HOME HEALTH AGENCIES LEGAL SERVICES FOR DURABLE POWER OF ATTORNEY, ETC.

For copies of the Mini-Mental State Exam and the Geriatric Depression Scale write: Dr. Brenda Keller, University Geriatric Center, 600 South 42nd Street, Omaha, Nebraska 68198-5620.

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PERINATAL PAGE

Problems and Outcomes in Low Birth Weight Infants

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SURVIVAL rates in low birth weight infants have improved greatly in the United States in the last 30 years. In 1960 there were 12354 survivors out of 49936 infants (24.7%) born in the U.S. with a birth weight less than 1500 grams.[1] In 1986 there were 45469 infants born in the U.S. with a birth weight less than 1500 grams and 28882 survivors (63.5%).[1] Since 1986 the wide spread use of replacement surfactant has further improved mortality rates in low birth weight infants.

As health care reform becomes a dominant theme of the 1990's, it is of central importance to closely examine the morbidity and mortality associated with premature birth. The purpose of this manuscript is to briefly review the medical problems encountered in low birth weight infants, and to provide primary care physicians with the most recent regional statistics on outcomes in low birth weight infants.

Care of very low birth weight infants is a tremendous challenge for health care providers. The patients have complex and unique medical problems. When there is sufficient time, maternal transport to a tertiary perinatal center is recommended.[2] A physician experienced in neonatal resuscitation should be in attendance at these high risk deliveries. It is not uncommon that difficult ethical decisions must be made on how aggressive delivery room resuscitation should be for those extremely low birth weight infants born at the threshold of viability.[3]

To maximize outcome potential in very low birth weight infants, meticulous attention must be provided to multiple factors. Following delivery attention must first be directed toward the infant's cardiorespiratory status. Nearly all very low birth weight infants require mechanical ventilation and surfactant replacement. High frequency ventilation may also be of benefit to select patients. Extremely premature infants often require inotropic support, intravascular volume augmentation, and medical or surgical ligation of a patent ductus arteriosus. Very immature infants are vulnerable to cold stresses; it is of critical importance to provide an appropriate thermal environment. Fluid and electrolye balance is particularly challenging in these patients because of their renal immaturity and profound insensible fluid losses. Nutritional support is initiated intravenously since preterm infants are at risk to develop necrotizing enterocolitis. Premature infants also have immature host defense mechanisms, are predisposed to life-threatening infections, and frequently require broad-spectrum antibiotic coverage. Finally, there is much parental anxiety associated with the hospitalization of a critically ill newborn. Family centered care is an important goal in newborn intensive care units. Therefore, social workers, developmental specialists, clergy, and ethicists play key roles in the comprehensive approach to the care of these infants.

It should be of no great surprise that neonatal survival rates increase significantly with increasing gestational age and increasing birth weight. Infants born earlier than 24 weeks gestation and with birth weights of less than 500 grams rarely survive.[4] Although survival of neonates of 22 and 23 weeks of gestation have been reported, some have questioned the validity of these reports since there is difficulty in determining the gestational age of infants born at less than 28 weeks of gestation.[4]

There are several methods to assess the gestation age of premature neonates. The Dubowitz scoring method of gestational age assessment relies upon features of physical and neuromuscular maturity.[5] The Dubowitz method is most useful in determining gestational age if the infant is greater than 32 to 33 weeks gestation. Ophthalmological examination of the anterior capsule of the lens is an easy and relatively reliable method to determine gestational age for infants born at greater than 27 weeks of gestation. Infants born between 27 and 34 weeks gestation have predictable loss of vascularization of the anterior capsule of the lens.[6] In contrast, infants born prior to 27 weeks of gestation have complete vascularization of the

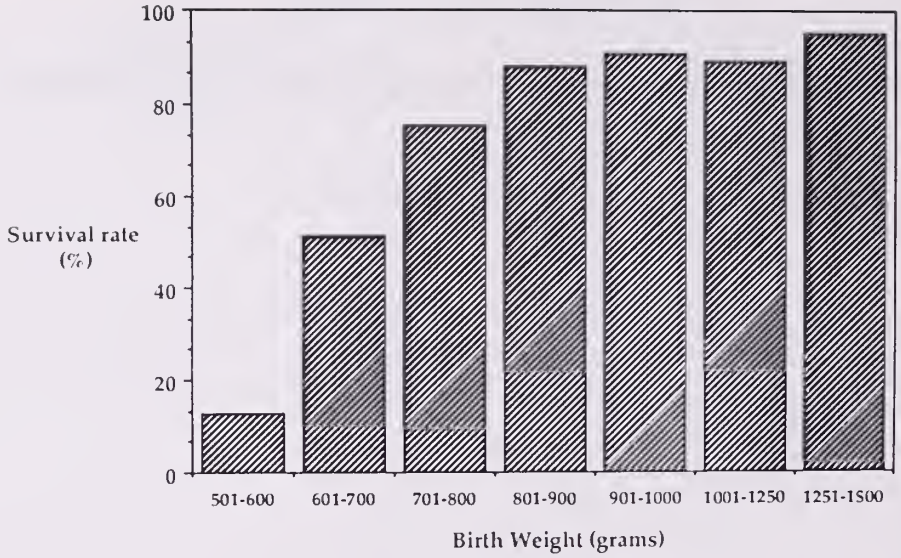

FIGURE 1
Survival rates by birth weight of premature infants hospitalized in the Newborn Intensive Care Units at St. Joseph's Hospital and University Hospital from 1989 to 1992.

anterior capsule of the lens and thus cannot be distinguished from each other. Fusion of the eyelids is another physical feature that is used to approximate the gestational age of infants born at the threshold of extrauterine viability. A newborn with fused eyelids is usually considered to be less than 26 weeks gestational age. However, even this physical feature is subjective since eyelids are "tightly fused" at less than 24 weeks gestation and "loosely fused" at 25 and 26 weeks gestation.[6]

Birth weight is frequently used to analyze survival rates of premature infants. Since birth weight is dependent upon a number of fetal and maternal factors including race, ethnicity, sex, altititude, and nutritional status, one must exercise caution in interpreting survival statistics exclusively by birth weight. Newborns with any given birth weight have wide ranges in gestational age even if they are born prematurely. For example, the gestational ages that include the 10th to 90th percentile distribution of a 550 gram infant includes gestational ages between 22 and 26 weeks.[2]

It is imperative that individual centers caring for low birth weight infants frequently monitor their outcome statistics. Since 1989 the neonatologists of the Joint Division of Newborn Medicine, Creighton University/University of Nebraska Medical Center have utilized the Neonatal Information System (N.I.S.) as a computerized database to monitor and assess outcomes. The Figure demonstrates the survival statistics of patients we have cared in the last four years. These survival rates are comparable to those reported in large multicenter studies as well as those recently reported at the National Neonatal Database Meeting (October, 1993).[4]

In conclusion, survival rates of premature infants have improved significantly in recent years. However, infants with birth weights less than 700 grams remain particularly challenging because of profound immaturity of multiple organ systems. Hopefully, further advances in neonatal medicine will improve the morbidity and mortality associated with extremely premature birth.

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COMMUNICATION

Professional Courtesy - Ethics and the Law In The Medical Treatment of Physicians and their Families

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A majority of medical schools are reported to have one or more courses in medical ethics and a few continuing medical education courses or meetings are reported to deal to some extent with medical ethics matters.[1] However, there appears to be a very large number of practicing physicians who do not follow the old time (pre-Medicare) practice of professional courtesy or the more recent opinion of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws of the American Medical Association. It is also noted that the Medicare Regulations (which have the full force of Federal Law) are very specific about some charging practices which were formerly considered to be purely courtesy or ethical matters.

The ethics, courtesy and legal aspects of providing and charging for medical care services to another physician and his family need to be well understood by all physicians. Widespread differences in handling this matter among physicians as a group and even different methods at different times by the same physician suggests that this whole matter is not widely understood and that a very large number of physicians are in violation of courtesy or ethical standards and also the law pertaining to the matter.

The 1955 AMA Code of Ethics is not contained in the current version of the Code, published in 1992 under the title Code of Medical Ethics: Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association. Current Opinions does not address the issue of professional courtesy, defined as "the provision of care to other physicians and their families free of charge or at a reduced fee". However, the Council on Ethical and Judicial Affairs (formerly the Judicial Council) does have a policy on the routine waiver or forgiveness of insurance deductibles and co-payments.

The AMA Principles of Medical Ethics adopted by the House of Delegates in 1980 is a revision of the older Code adopted in 1957 and does not specifically address the matter of courtesy or charging practices in the care of another physician and his family who are patients.

Reports C and D of the Council on Ethical and Judicial affairs presented to the House of Delegates at the annual meeting in 1993 were considered to be informational and were filed, as is the custom with such reports.[2] The reports do reflect policy and it is expected that all members will comply, or follow the advice given in the opinion.

Informational material from the AMA and private insurance industry is silent on the matters of definition of immediate family and also how to handle the charges (if any) in the care of a colleague (and his immediate family) who is a partner or a member of the same corporate practice group. This may be a close call for some when insurance benefits are involved, as they usually are. By definition, professional courtesy is a no charge. Insurance deserves no consideration here. Certainly courtesy would be ethical and legal. If there is no charge, then there is no expense and if there is no expense, there is no benefit from private or governmental sources. Providing medical care to an associate, his or her spouse and family is a privilege, an honor and a compliment.

With respect to providing medical care to other physicians (and their immediate families) with whom one is not associated in practice, the recent opinions of the AMA, the Medicare law and the private insurance industry are in general agreement as follows:

1. Physicians generally should not treat themselves or members of their immediate family (with a very few obvious exceptions) for many obvious reasons.[3] There is therefor no reason for charging, billing insurance companies or governmental agencies nor any question of unethical, discourteous behavior, or illegality. If a charge is made to an insurance company or governmental agency in such cases,

that would be considered to be fraud and legal prosecution with severe penalties could follow.

2. Physicians may ethically and legally charge other physicians and their families for medical care and services. It is apparently very widespread practice for the treating physician to take an assignment of insurance or Medicare benefits in such cases and to accept the insurance or Medicare benefits as full payment for the services. This is not legal for Medicare or private insurance and is not in accordance with AMA policy. Routine forgiveness of deductibles and coinsurance is specifically addressed as being illegal by Medicare law.[4] The part B carrier has no discretion to alter the regulations. Deductibles and coinsurance cannot be forgiven as a professional courtesy.[4] Ordinarily they may be forgiven only in cases of financial hardship or when repeated sincere efforts to collect are unsuccessful. AMA Opinions clearly state that routine forgiveness of deductibles and copayments may be considered fraud under federal and state law.[2] Private insurance companies believe that their contracts which call for deductibles and/or coinsurance should be enforced and considered in the same way as spelled out more specifically in Medicare law. They believe that waiving such payments does not then reveal to them what the real charge has been, that it is often inflated, and it adds significantly to the cost of health care coverage, that it encourages over-utilization of services and procedures and is often used as a ploy to attract more patients.[5]

3. Medicare regulations regarding charges for services provided to his or her immediate relatives have been sent to all physicians and should be reviewed carefully again. If lost or misplaced, any Part B carrier will provide a copy on request. In general, an immediate relative is a spouse, child, sibling, parent, grandparent or grandchild. Also included are the spouse's parents and siblings (but not the siblings' spouses and children). Medicare payment is also excluded for care or services to patients who share a common abode with the treating physician as a single family unit. Examples are full-time employed, live-in maids, butlers and chauffeurs.[6] Immediate relatives are not defined by AMA or private insurance contracts but both intend that physicians should follow the Medicare definitions.

Almost all physicians carry some medical insurance. This would be private insurance prior to Medicare eligibility. It could be personal private/family insurance, Association group insurance such as through AMA, ACP, AAFP, etc. or employer/employee insurance in a general or professional corporation. In all cases the physician or family patient should be treated the same as all other patients in charges, assignment of insurance benefits and collection of deductibles and coinsurance. Nearly all physicians who become patients surely desire and expect such treatment in financial matters.

Many physicians carry medical expense insurance with a relatively high deductible such as $500 to 1500 or even higher. Such coverage has considerably lower premiums. Even if the usual and customary charges do not reach the deductible level, the physician/family patient should be charged and billed and expected to pay for services. He will have saved more than enough in premiums over the years to pay for the deductibles.

Many physicians do not elect to take Medicare Part B coverage although that is automatic unless the physician notified Medicare to the contrary. Again, this does not relieve them from the responsibility and courtesy of paying their own way.

Most eligible physicians do have Part B coverage. Professional courtesy would suggest that an assignment of benefits be taken and a bill sent for the deductible and coinsurance.

Many physicians carry Medicare supplemental insurance of some kind which will cover most of the deductible and coinsurance charges, only rarely all of them. Acceptance of assignment of these benefits is more optional as many treating physicians do not send statements to secondary carriers. It would be a courtesy.

Many physicians and others do not believe it saves any money and usually costs more to pay premiums on the supplemental coverage than to pay the deductible and insurance out of pocket. Many examples could be cited. Some people believe in carrying lots of insurance and others prefer to carry the minimum. Certainly everyone should have medical expense insurance in the catastrophic range, above $2 to 5 thousand, for example.

ASK A LAWYER

1. **What are the basic principles of the Nebraska Hospital-Medical Liability Act?**

The Nebraska Hospital/Medical Liability Act was passed by the 1976 Legislature as an alternative method for resolving malpractice claims. The Act applies to professional liability problems associated with physicians, nurse anesthetists, and certain facilities such as hospitals.

The ultimate goal of the Act is to encourage physicians to practice medicine in Nebraska, thereby ensuring the availability of competent medical and hospital services to the public in the State of Nebraska. This alternative was designed to provide prompt and efficient methods for eliminating nonmeritorious malpractice claims, efficient methods for resolving meritorious claims, improved availability and quality of medical care, reduction of the costs of medical care, and availability of malpractice insurance coverage at reasonable rates.

2. **How does the Act effect limits of liability?**

If either the physician or patient has chosen to be excluded from the Act, there is no limit of liability. If, on the other hand, both the physician and patient are included under the Act, the liability of the physician is limited to the amount of his or her basic insurance coverage. The total award, however, for any occurrence resulting in the injury or death of the patient may be as high as, a) $500,000 for any occurrence on or before December 31, 1984, b) $1,000,000 for any occurrence after December 31, 1984, and on or before December 31, 1992, and c) $1,250,000 for any occurrence after December 31, 1992. The difference between the physician's insurance coverage and the maximum award limit would be paid out of an "Excessive Liability Fund." (Consult the full text of the Act for more specific limitations and alternatives.)

3. **How do physicians qualify under the Act?**

A physician is not obligated to be included under the Act. If a physician elects to be included under the Act, he/she must take affirmative action to do so, including the following:

a. Sending to the Nebraska Department of Insurance proof of basic professional liability insurance coverage from an insurance company qualified in Nebraska in the amount of $200,000 for each occurrence. (In the case of physicians or nurse anesthetists and their employers, partners, etc., an aggregate liability amount of $600,000 for each occurrence and for each insured shall be provided; in the case of hospitals and their employees, an aggregate liability amount of $1,000,000 for all occurrences shall be provided);
b. Making an annual payment not to exceed 50% of the premium of the basic liability insurance coverage for the creation of an "Excess Liability Fund." (This payment is adjusted annually by the Nebraska Department of Insurance); and
c. Displaying in a suitable location an approved notice that the physician has elected to be included under the Act.

4. **How do patients qualify under the Act?**

Patients are also not obligated to be included under the Act. A patient is "conclusively presumed" to be included under the Act, however, unless the patient takes affirmative action to exclude himself/herself from the Act. To exclude oneself, a patient must do the following:

a. File a written election to be excluded to the Insurance Director of the State of Nebraska prior to treatment;
b. Renew this election every two years; and
c. Notify the physician as soon as is "reasonable under the circumstances" that he/she has so elected.

***

"Ask a Lawyer' is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen Jr. with the assistance of UNL College of Law student Jane Kemper of the Cline Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

ALLIANCE

AMA-ERF

DESTA OSBORNE
NMAA Legislative Chairman

The NMA Alliance is sponsoring a Legislative Day on February 24. The NMA and the NMAA is invited and encouraged to attend. If you can spend only part of the day please let us know that also. By working and learning together we can better deal with the challenge of change medicine is encountering.

Dr. Allen Dvorak, Chairman of the NMA Commission on Legislative and Governmental Affairs will be discussing how the NMA arrives at decisions on supporting or opposing various issues. Much work has already been done but much is yet ahead. This is your opportunity for input.

Below is the complete agenda for thd day.

LEGISLATIVE DAY
Thursday, February 24, 1994, Lincoln, Nebraska

This is the year for you to get involved. By acting together we can make a difference in legislation.

Changes in health care concern us all. February 24th is NMAA Legislative Day and we have speakers and activities that deal with the issues.

9:15 a.m. ..... Meet at the Capitol, 1445 K Street, room 1200 (street level)

9:30 a.m. ..... KIM ROBAK, Liuetenant Governor - Health Care Policy for Nebraska

10:00 a.m. ..... ALLEN DVORAK M.D. NMA Commission on Legislation and Governmental Affairs
DAVID BUNTAIN, Lobbyist, Legal Council NMA. Current issues and bills affecting medicine in Nebraska

10:30 a.m. ..... Time permitting: Legislative process. Tips on influencing legislation, tour Senators' offices

11:30 a.m. ..... Lunch at the Nebraska Club, 13th & M Street, top of FirsTier Bldg.
SANDRA MITCHELL, guest speaker AMAA Field Director; National health policy of the AMA

12:30 p.m. ..... NMAA Mid-winter Meeting, BARB BOHI, NMAA President presiding

PARKING: Car Pooling with other members is suggested. FirsTier Building 13th & M
East of FirsTier: Agee's Towne Parking & Metropolitan Federal; Limited around Capitol, 14th & K

Please return the form below by February 18, 1994
Mail to: Dottie Shapiro — 7410 Old Post Road #8, Lincoln, NE, 68506
402-489-5372

LEGISLATIVE DAY — THURSDAY, FEBRUARY 24, 1994

I will attend: Legislative Day at the Capitol _____ Lunch at $10/person _____ Mid-Winter Meeting _____

Make checks payable to Nebraska Medical Association Alliance (NMAA)

Name _____

Address _____

City _____ Telephone _____

Mini-internships organized by county Societies/Alliances/Auxiliaries — including Omaha and Lincoln — have already been held and have helped legislators, community leaders, and business executives gain a first-hand understanding of health care issues by spending a day with physicians on rounds, in surgery and with patients. More of these programs are planned.

There are many ways of expressing your views to legislators that are vital. For example: register and vote, letter-writing campaigns, phone banks, and key contact systems. The key is to act. If you are interested in doing projects in your area and need more information, please let us help you.

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Susan L. Ryan, M.D.
2833 S. 87th Ave.
Omaha, NE 68124

COMING MEETINGS

UNIVERSITY OF NEBRASKA MEDICAL CENTER MEDICAL EDUCAATION

SATURDAY, FEBRUARY 12, 1994 — 3rd Annual Advances in Diagnosis and Management of Cardiovascular Diseases, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Primary Care Physicians and Cardiologists. Fee: $25.

SUNDAY-FRIDAY, MARCH 6-11, 1994 — 14th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MONDAY, MARCH 14, 1994 — Heartland Risk Reduction Society Meeting, Dinner/Program (6:30-9:00 p.m.), Omaha, Nebraska. Target Audience: Health care providers who treat patients with atherosclerotic vascular diseases. Fee: $10.00.

11 DAYS, MARCH 14-25, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY - SATURDAY, APRIL 14-16, 1994 — 2nd Annual Diagnostic Dilemmas in Women's Health Care, Marriott Hotel, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Fee: $200.

11 DAYS, APRIL 18-29, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY-FRIDAY, JUNE 12-15, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Obstetrics and Gynecology, Oncology/Hematology & Researchers.

THURSDAY-SATURDAY, JULY 14-16, 1994 — 1994 National Conference on Family Violence: Research and Practice, Holiday Inn Centre, Omaha, Nebraska. Target Audience: Multidisciplinary (health professionals, sociologists, criminal justice)

TUESDAY-FRIDAY, JULY 19-22, 1994 — Pan Pacific Lymphoma Conference, The Ritz Carlton - Mauna Lani, Kohala Coast, Hawaii. Target Audience: Oncology/Hematology & Researchers.

FRIDAY-SUNDAY, AUGUST 19-21, 1994 — Imaging and Breast Cancer, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians.

MONDAY-SATURDAY, SEPTEMBER 19-24, 1994 — Emergency Medicine Review, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

MONDAY-SATURDAY, OCTOBER 3-8, 1994 — Emergency Medicine Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

ONGOING CONTINUING MEDICAL EDUCATION PROGRAMS

ADVANCED CARDIAC LIFE SUPPORT — Provider, Renewal and Instructor.

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ADVANCED TRAUMA LIFE SUPPORT — Provider and Reverification.

ADVANCED LIFE SUPPORT IN OBSTETRICS — Provider

These programs are offered by the Center for Continuing Education throughout the year.

For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuting Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

CREIGHTON UNIVERSITY

FEBRUARY 7, 1994 — Fetal Malformations Associated with increased MSAFP - OB Outreach Program at Offutt Air Base, Omaha, NE.

FEBRUARY 10-14, 1994 — Anesthesiology Review Course - Professional Seminars - Las Vegas, NV.

MARCH 5-6, 1994— Fourth Annual: Anesthesiology Conference - Health Care and Reform - Marriott Hotel, Omaha, NE.

MARCH 7, 1994 — Obstetrical Complications - OB Outreach Program at Offutt Air Base, Omaha, NE.

MARCH 12, 1994 — Colon and Rectal Diseases Conference - Embassy Suites, Omaha, NE.

APRIL 3-9, 1994—Anesthesiology Review Course - Professional Seminars - Orlando, FL.

APRIL 4, 1994 — Medical Complications - OB Outreach Program at Offutt Air Base, Omaha, NE.

APRIL 15, 1994 — Distinguished Lecture Series - Henry J. Mankin, M.D. - St. Joseph Hospital Seminar Room.

APRIL 22-23, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

MAY 2, 1994 — Abruptio Placenta - OB Outreach Program at Offutt Air Base, Omaha, NE.

MAY 19-22, 1994 — A Review of Orthopaedics and Orthopaedic Pathology - Criss II Building, Creighton University, Omaha, NE.

MAY 27-29, 1994 — Family Medicine Update, Okoboji, IA.

JUNE 6, 1994 — Medical Therapy of the Fetus - OB Outreach Program at Offutt Air Base, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

AUGUST 12-13, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 2500 California Street, Omaha, NE 68178.

UNIVERSITY OF KANSAS MEDICAL CENTER

APRIL 15-17, 1994 - 44th Annual Postgraduate Symposium on Anesthesiology, Ritz-Carlton Hotel, 401 Ward Parkway, Kansas City, MO. Sponsor: Dept. of Anesthesiology, University of Kansas Medical Center. Target Audience: Anesthesiologists, nurse anesthetists, family physicians. Fees: To be announced. Credit: AMA Category 1 of the Physician's Recognition Award: 16.5 hours American Academy of Family Physicians: to be announced, American Association of Nurse Anesthetists: to be announced, American Nurses Association: to be announced.

Contact: Office of Continuing Education, KU Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160-7108.

MAYO FOUNDATION

FEBRUARY 10-12, 1994 — Mayo Clinic State-of-the Art Symposium: Arrhythmia Management, Napa Valley, CA.

FEBRUARY 21-25, 1994 — Neurology in Clinical Practice, Keystone Resort, Keystone, Colorado.

Contact: Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688.

NEBRASKA MEDICAL ASSOCIATION

ANNUAL SESSION - House of Delegates, April 28-May 1, 1994, Marriott Hotel, Omaha.

FALL SESSION — House of Delegates, September 15-17, 1994, Cornhusker Hotel, Lincoln.

OFFICE OF CONTINUING MEDICAL EDUCATION
WASHINGTON UNIV. SCHOOL OF MEDICINE
St. Louis Missouri

THURSDAY-FRIDAY, APRIL 21-22, 1994 — Symposium On Obstetrics & Gynecology, Location: St. Louis, Missouri.

FRIDAY-SUNDAY, JUNE 24-26, 1994 — Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862 Interstate, (314) 362-6893 In Missouri, FAX (314) 362-1087.

OFFICE OF CONTINUING MEDICAL EDUCATION

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THURSDAY, JUNE 17, 1993 • State of the Art Clinical Symposium on Allergic Diseases, Location: The Ritz-Carlton Hotel, St. Louis, Missouri, Program Chairman: Phillip E. Korenblat, M.D.

FRIDAY-SATURDAY, September 10-12, 1993 • Frontiers In Endosurgery: Advances in Endourological Techniques and Technology, Location: Washington University Medical Center, St. Louis, Missouri, 18.5 credit hours AMA Category 1, Program Chairmen: Ralph V. Clayman, M.D. and Elspeth McDougall, M.D.

FRIDAY-SATURDAY, SEPTEMBER 17-18, 1993 • Physician Executive Leadership, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairmen: Walter F. Ballinger, M.D. and James Hepner, M.D.

SATURDAY, SEPTEMBER 18, 1993 • Suicide, Location: St. Louis, Missouri.

OCTOBER 6-14, 1993 • Allergy Abroad: Holland and Brussels, Program Chairman: Phillip E. Korenblat, M.D.

THURSDAY-SUNDAY, NOVEMBER 11-14, 1993 • Anesthesiology & The Geriatric Patient, Location: St. Louis, Missouri.

NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

BENJAMIN R. GELBER, M.D., EDITOR
Nebraska Medical Journal
2221 South 17th Street, #310 • Lincoln, NE 68502

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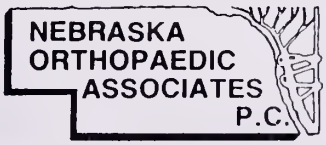

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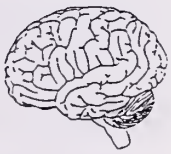

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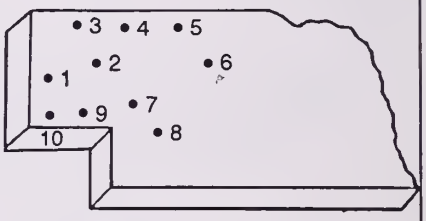

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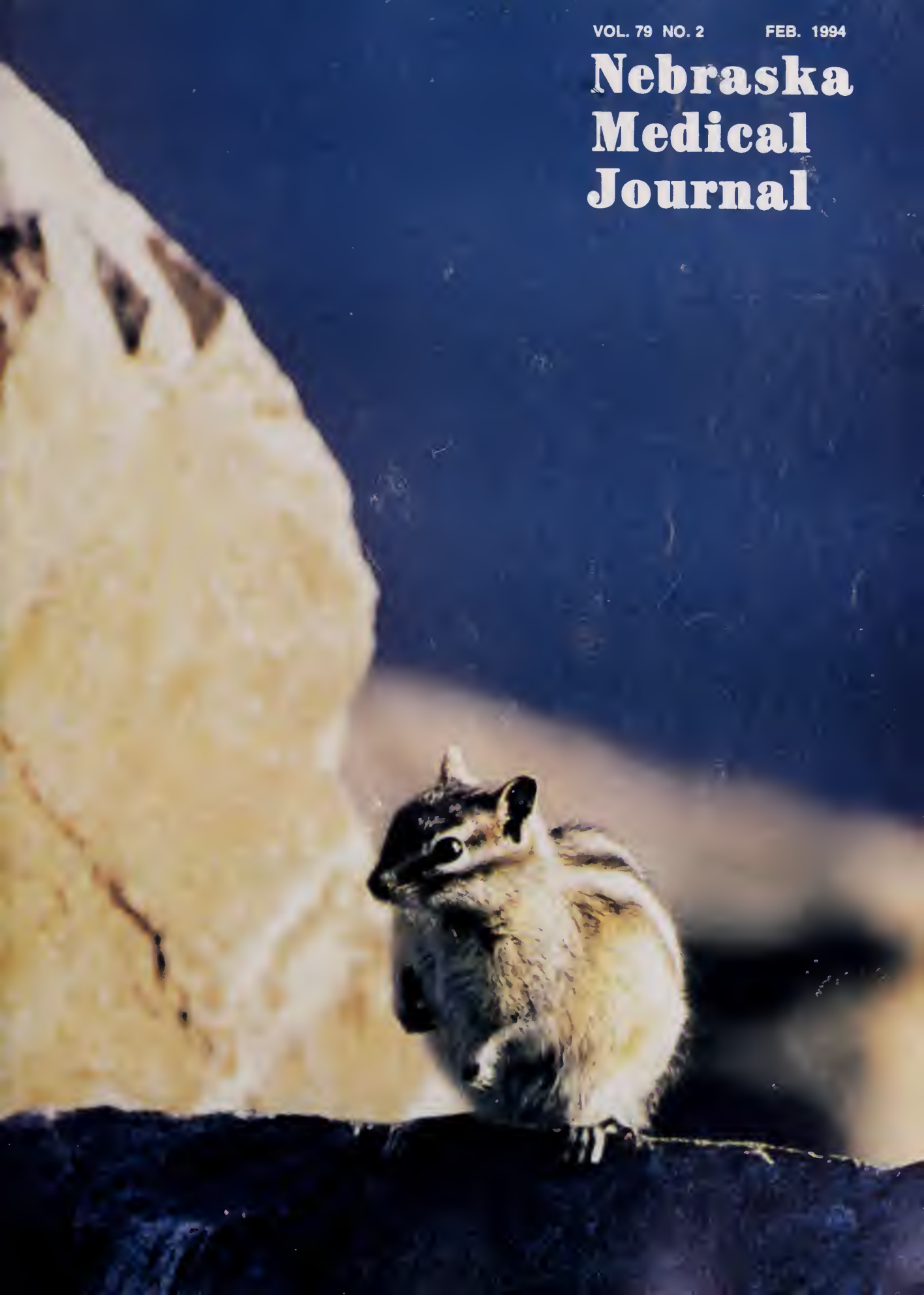

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AMA NEWS NOTES

AMPAC STUDY DRAWS NO CREDIBLE CONCLUSIONS

Findings of a recent report on AMPAC contributions do not draw any credible conclusions, said AMA EVP James S. Todd, MD, responding to an article in the current edition of *New England Journal of Medicine*.

The report concluded AMPAC contributed to members of Congress who hold opposing views to three AMA public health issues.

The AMA said the study looked at too narrow a range of health issues to be representative of the Association's overall lobbying efforts.

"AMPAC activities are only one of many lobbying and information programs conducted by the AMA," Dr. Todd said. PAC contributions and public health funds, he pointed out, are actually two different pools of money.

The report's authors, he said, neglected to analyze "the broad range of areas where the AMA attempts to influence legislation on behalf of the public and medical profession."

"Interestingly, the authors themselves raise serious questions about the methodology and conclusions of their own study" Dr. Todd said. "A subject of this complexity does not easily lend itself to a relatively simplistic approach."

* * *

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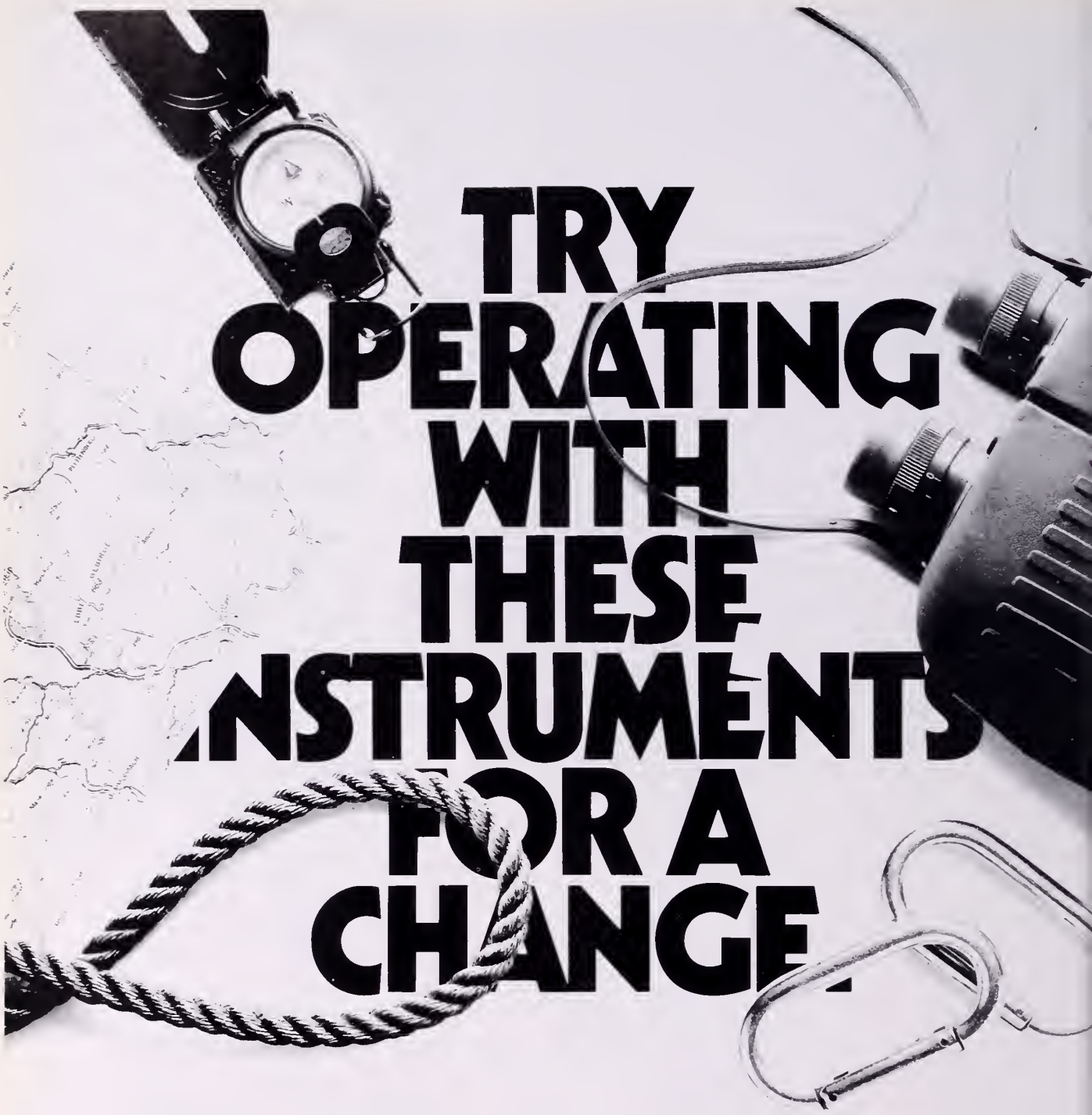

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PRESIDENT'S PAGE

Senator Kerrey and Health System Reform

ROBERT F. SHAPIRO, M.D.

On a cold, sunny December Friday afternoon, Senator Bob Kerrey, in his words, "held a conversation about health system reform" at Lincoln General Hospital. His audience included a few medical staff physicians, administrative staff, and numerous hospital employees. He spent an hour making brief introductory remarks and answering questions.

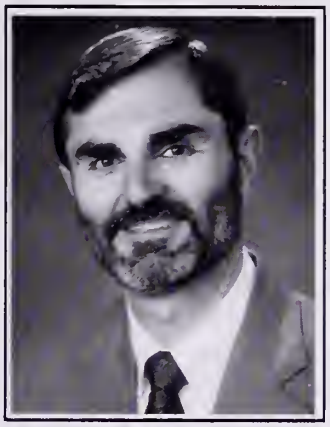
Senator Kerrey said he did not intend to introduce his own version of health system reform even though, just as with Clinton's tax legislation, he had serious concerns about aspects of the Clinton proposal. He believed it was the best vehicle to develop a definitive program for health system reform, because other approaches had even more serious deficiencies.

Questions from the group were polite; his answers general and not intended to antagonize the audience (similar to Hillary Rodham Clinton's style of addressing the AMA House of Delegates last June).

A recurring theme in past editorials has been that underlying philosophies and beliefs are powerful forces, which are expressed in a person's approach to problems and the choices they make, and I listened for ideas which might reflect such values to discuss in a President's Page.

Senator Kerrey did not disappoint me. I was hooked by two of his ideas. Answering a question about cost containment and technology, he observed that some years ago, an ophthalmologist required one and a half hours to perform cataract surgery which cost $1500. Today it takes fifteen minutes, he was told, and still costs $1500; he thought that was wrong. Later, while discussing how to finance the health care system, he said we should pay for health care based on our ability to pay. Most proposals are avoiding progressive taxes like the plague.

• Since Senator Kerrey's comments about cataract surgery did not specify time frame nor



Robert F. Shapiro, M.D.

procedural differences, I thought there was more to this issue than meets the eye.

• Medically, were we talking about the same cataract procedure? As we know, cataract surgery was an inpatient procedure, the patient hospitalized up to ten days, and the head immobilized by sandbags. There were added inpatient hospital costs, which may or may not have been greater than current outpatient facility costs. But if you factor into the equation that with today's intraocular lens implant, a person may have better vision than before the cataract developed and use glasses that, cosmetically and optically are far superior to the "coke bottle bottoms" which patients tolerated; we can appreciate it is a better procedure technically and a better value.

• Another consideration was maybe Senator Kerrey knew that with personal computers, VCRs, or compact discs, when technology becomes widespread and easier to produce, prices go down. This does not seem to occur with medical procedures, ignoring the fact that services and manufactured goods are not the same.

• Neither idea, technical issues or production costs, seemed to accurately identify the philosophy underlying Senator Kerrey's com-

ments. I decided his fundamental idea, because he emphasized only time to perform the procedure, must be the "Labor Value Theory". Making this concept viable frustrated central planners in the former Soviet Union for fifty years. Edward R. Annis, M.D. in his new book on our health care system, CODE BLUE, notes this philosophy dominates the RBRVS.

Underpinning the philosophy is the notion that value is totally tied to the labor going into production. While no one argues that labor is not integral to the value of a service, it is only one factor. Carried to logical extreme, the assumption becomes any product or unit of service, by whomever produced, is the same as any other product or unit of service; and therefore any difference in price should only be a function of the time required to produce it; which seemed to me to be the essence of what Senator Kerrey was saying.

My purpose is not to impugn Senator Kerrey's idea, because, as Dr. Annis demonstrated, physicians accept the "Labor Value Theory". If we didn't and truly believed in a free market, we wouldn't be so concerned when prices of procedures varied by ratios of 4-5 to 1, nationwide; we would expect it.

We spend time, effort and energy hoping to adjust RBRVS values to make them "fair". We are coming to accept this concept as a way of flattening the physician income curve by relating economic reward to hours worked. Tolerance for differences related to a physician's particular skills, marketing abilities, location, luck, or liability has narrowed sharply.

Economic competition with other physicians can make us uncomfortable. We are unhappy when others charge less and equally unhappy when others are able to command higher fees. In reality, we might prefer competing like airlines before deregulation. Then, competition was about providing value added amenities; with basic services provided at rates, which as long as you could generate passengers, virtually guaranteed a desired rate of return.

If Senator Kerrey's thought is indicative of his colleagues' thinking and not unique to him, we might forecast that "time" will become an even more significant factor in determining reimbursement for professional services. It could become critical to prove time is only one factor in the cost structure of providing a service; and to justify realistic valuation of other factors.

• Funding health care costs based on people's ability to pay is not a topic I would ordinarily tackle. As physicians, our primary concerns relate to the results of funding: access to care for our patients, free choice of physician, adequate funding to insure that services can be provided, continued development of new technologies and medicines to enable us to improve care for our patients, and reducing the hassle in the medical environment. Funding, itself, is a political issue.

On the other hand, as citizens as well as physicians, much time and energy were spent at the AMA meeting in New Orleans, at times heatedly, discussing possible adverse effects of an employer mandate on jobs in their communities. Ultimately, action was taken to broaden the AMA's flexibility in considering other financing options while not rejecting employer mandates, a feature of Health Access America, common to it and Clinton's Health Security Act. In this context, I felt funding was fair game for discussion.

Years ago, medical care was informally funded based on ability to pay. Dr. Annis examined this idea in CODE BLUE. The poor were cared for without direct cost to them; but the well-to-do were charged a high price. Later, with the advent of health insurance, it was decided that medical services had definite values; and therefore this informal mechanism was not inappropriate. We moved to setting fees by a schedule or by "usual and customary".

Where possible, hospitals and doctors "shifted" costs of caring for the uncovered poor onto the prices of services for other patients. Medicaid and Medicare, both expensive programs, provided funding for specific categories of poor and/or the elderly.

Today a major problem is financing universal health care. Although not delineated as a right in the constitution, health care has come to be perceived as such. With a right comes a responsibility to fulfill that right. Since the government can only generate resources to fulfill rights by taxing citizens or mandating the allocation of resources, the question can only be who pays and how much.

The Clinton Commission asserted that, on average, costs of health insurance for the standard package of benefits for an individual would be around $1800 and for a family in the $4300 range. Recognizing that some people use fewer

services and others more, the actual average value of the coverage is probably close to these numbers.

What this means is that because many individuals or employers may not be able to cover those costs, other Americans will need to pay more. How much more?

Surveys done by Robert Blendon from Princeton, showed that people are willing to pay more than required to fund their own protection in order to help others who can't finance their coverage; however, that extra amount they are willing to pay is finite. Blendon's studies suggest that around 50% of Americans would be willing to pay up to $50 a month more, but no more.

Senator Kerrey implied that current and suggested approaches were regressive and said he favors a progressive approach like the income tax, based on ability to pay, and did not specify a "cap" such as formerly existed on income subject to the Medicare tax.

I agree that most of us are willing to pay more to help those who can't provide for themselves, but I believe that to structure financing to shift the costs to a small group of higher income taxpayers will be no more acceptable than were the proposed taxes to fund the Medicare catastrophic coverage, which was a fiasco several years ago. I think this is why most proposals look to "premiums" and want to avoid the word "taxes" if possible.

Bringing 38.5 million people into the system as covered individuals rather than being absorbed as "shifted costs" is a societal problem and should require everyone to assume a "proportionate share" with a reasonable cap and not be an open ended "progressive income tax burden". "Sin" taxes, which recoup extra costs created by poor lifestyle choices, could also be appropriate.

EDITORIAL

The Physician Citizen and Politics

CHARLES S. WILSON, M.D.

It has been said that in a democratic society we get the government we deserve. There are several profound implications to this statement, one of which is if we don't participate in the political process we should not complain about the government the process produces. And yet physicians, who individually and collectively have concerns and frustrations with many aspects of government as it impacts their professional and personal lives, generally consider "politics" something foreign and repugnant.

According to Webster's dictionary, the word politic comes from the Greek politikos, which means "relating to a citizen". The physician is certainly a citizen, no less than a lawyer, farmer, teacher, or businessman. However, a quick view of the political process reveals a low level of physician participation. Governing bodies, from city councils and school boards to state legislatures and the Congress of the United States, have a paucity of physicians in their membership. There is similar under-representation of physicians amongst the political party organizations at the county, state, and national levels, and in the campaign organizations of political candidates.

I have read that one-fifth of the delegates to the last Democratic Party national convention were teachers and/or representatives of state or national teachers' organizations. How many physicians were delegates to either party's national convention? A handful. The Nebraska State Legislature has no physician senators. The United States Senate includes no physicians. The 435 member U.S. House of Representatives includes only two physicians in its ranks. And how many lawyers? How many businessmen and farmers? A bunch.

The current debate on health care "reform" is being carried out in state and national legislatures which are essentially or in fact devoid of physicians. The physicians' perspective is represented through lobbying efforts rather than active and direct participation in the legislative process. Think how differently the approach to health care issues (or legal tort reform) might be if the president and a substantial percentage of the congress were physicians rather than lawyers. Or for that matter, if one-fifth of the delegates to either party's national convention were physicians rather than teachers.

Physician participation in the political process is necessary to represent the physicians' self-interest, a motive which clearly drives others such as farmers, teachers, lawyers, and businessmen to participate. However, more importantly, physicians bring special knowledge and unique experience in health related matters to a legislative process the outcome of which profoundly impacts all citizens.

Physician participation in politics and government can and should be an extension of our professional responsibility to work for better health for the individual and the public at large. Physicians can bring a special perspective to the discussion of issues such as violent crime, workplace safety standards, pollution, nuclear waste, tobacco subsidies, child nutrition, and government paperwork . . . not to mention health care "reform".

Physician should get involved in politics for the public good as well as their own. But how? Money of course is an essential fuel for the political process. For better or worse, that is a fact, and physicians should support worthy candidates financially. But I think physicians should do more than that; they need to get personally and actively involved in the process.

We need more physicians to seek and attain political office where they can shape public policy and laws. This usually involves considerable time and effort as well as financial sacrifice, but the satisfaction can be considerable. Physicians can also help identify and recruit good candidates for public office and give active support and advice to worthy candidates. Physicians should serve on campaign committees or campaign health care advisory committees. Physicians should serve in political party organizations at the county, state, and national level. Physicians should make personal acquaintance with their state senator, as well as their congressperson and their United States senators. The physician should communicate his or her views to these people by writing, or even better, calling them on important issues and legislation. A personal phone call or a direct personal meeting with an elected representative is especially effective. But how many of us do this on a regular basis, or ever?

Like it or not, politics affect our personal and professional lives profoundly. If you want to influence the outcome of the political process, you have to play the game.

ORIGINAL ARTICLE

Ocular Amyloidosis

IRA A. PRILUCK, M.D.
Division of Ophthelmology
Creighton University School of Medicine

OCULAR amyloidosis is an extremely uncommon ophthalmic disorder. There have been less than seventy-five reported cases in the world's literature. This ocular condition is characterized by vitreous opacification due to amyloid deposition. This paper reports a biopsy proven case of ocular amyloidosis in an individual with hereditary systemic amyloidosis.

The vitreous normally fills the posterior two-thirds of the eye. It is an optically clear jel consisting of 99% water and containing hyaluronic acid and collagen. With age, the vitreous undergoes a normal physiological alteration resulting in shrinkage, collapse, and separation from the internal limiting membrane of the retina. Certain areas of the collapsed vitreous body are relatively opaque, such as the attachment to the optic disc and can cast shadows on the retinal surface resulting in subjectively observed "floaters". Vitreal opacities can also occur in certain pathological conditions including vitreous bleeding, inflammatory cellular reaction, and from neoplastic cellular infiltration. Also included among vitreous opacifications are non-cellular deposition such as asteroid hyalosis (calcium soaps), cholesterolosis, and amyloidosis.

Case History

The patient is 76-year-old gentleman of Polish descent with a complaint of blurred vision and "floating specks". His family history was significant in that his younger brother died two years earlier from primary systemic amyloidosis. No other family members were reported to have this malady. Significant ocular findings included best corrected visual acuity which was 20/300, right eye and 20/80, left eye. Bilateral nuclear cataracts were present and intraocular pressures were normal. Slit lamp biomicroscopy of the vitreous cavity revealed 4+ opacification with amorphous material in the right eye and 2+ opacification in the left eye. Ophthalmoscopy was severely compromised by a whitish-yellow opacified vitreous. Ultrasonography of the right eye demonstrated highly reflective material consistent with amyloidosis and an attached retina (Figure 1). He had associated systemic findings of peripheral neuropathy, enter-opathy, and organic heart disease.

Trans pars plana vitrectomy, the surgical removal of the vitreous, was performed on the right eye and histological examination of the vitreous confirmed the diagnosis of ocular amyloidosis (Figure 2).

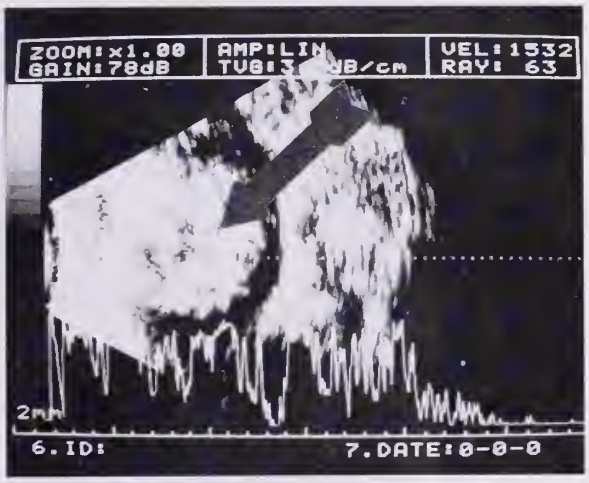


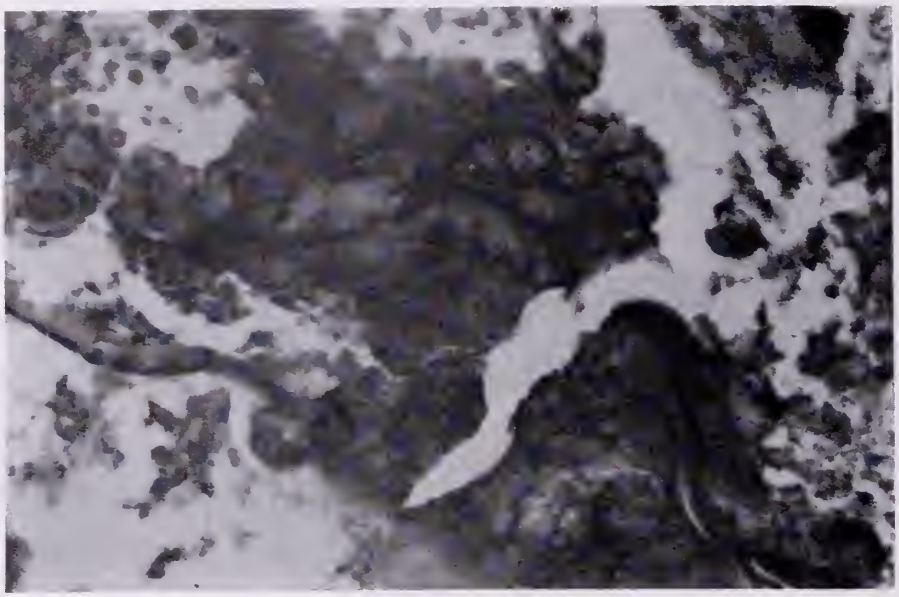
FIGURE 1
B-scan ocular ultrasonographyat 70 decibels demonstrates opacification of the vitreous cavity (arrow)

Post-operatively, the patient's vision improved to 20/50, right eye. The patients' final visual result was compromised by the pre-existing nuclear cataract.

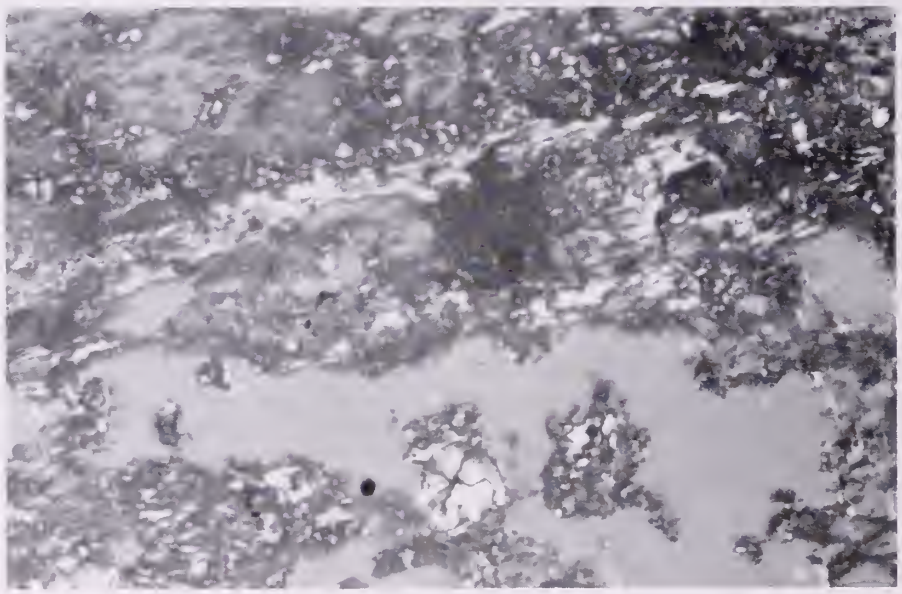
Discussion

Amyloidosis is a systemic disorder characterized by insoluble extracellular fibrous protein (amyloid material) accumulating in body tissues.

Friedreich and KeKule described "amyloid" degeneration in 1859.[2] In 1931, Magnus-Levy reported the relationship between Bence Jones protein, multiple myeloma, and amyloidosis.[3] Divry and workers reported the histological appearance of apple-green birefrigence when amyloid specimens were stained with Congo



2A



2B

FIGURE 2
Microscopic characteristics of amyloid include an eosinophilic homogenous substance stained with hematoxylin and eosin (A). Green birefringence occurs with Congo red stain as viewed with a polarizing microscope (B). And elecronmicroscopy shows fine, nonbranching fibrils measuring 70A to 90A in diameter (C).

red and viewed with polarized light.[4] It is this histological observation which is considered pathognomonic for amyloidosis. Glenner and workers reported the first amino acid analysis confirming that amyloid consists mainly of an immunoglobulin light chain.[5] Kaufman reported the presence of amyloid in the vitreous in 1958.[6]

Classification of amyloidosis includes idiopathic or primary amyloidosis. This type has no preexisting or associated systemic disease and is made up of light chains. This is the most common form and may be associated with multiple myeloma.

Biochemical analysis of the sub-unit protein composition is another way to categorize amyloidosis. In general, amyloid is basically not a single disease entity but rather reflects protein deposition which can occur in many varied organ systems with certain biochemical compositions. Amyloid deposits are often found in parenchymal organs including spleen, liver, adrenal glands, and kidneys.

2C

Secondary amyloidosis is due to amyloid A which is most likely derived from an acute phase reactant. This type occurs with chronic infections or inflammatory diseases such as rheumatoid arthritis, tuberculosis, or osteomyelitis. Another type is heredeofamilial amyloidosis which is clinically defined by history. This type involves ocular structures and is transmitted as an autosomal dominant trait. Ocular symptomatology may include blurred vision, diplopia, and blepharospasm. Patients with ocular manifestations of amyloidosis may have anisocoria, external ophthalmoplegia, retinal hemorrhages and exudates, retinal amyloid deposition, and vitreous opacification. The onset of vitreous opacification may occur prior to clinically recognizable amyloid deposition in other organ systems. Vitreous involvement is almost always bilateral and results in progressive and profound visual loss. The vitreous opacification occurs in a posterior to an anterior direction. The clinical findings of vitreous jel involvement is a "glass-wool appearance.[6,7]

Definitive diagnosis of this systemic disease may include rectal biopsy to obtain tissue for histological examination of needle aspiration of subcataneous fat.[8] Confirmation of ocular amyloidosis is based on histological examination of a vitreous biopsy obtained from pars plana vitrectomy surgery.

Vitreous surgery to remove the diseased vitreous is highly successful in restoring vision as well as providing a means to obtain a pathological specimen for a confirmatory diagnosis. Controlled cutting of the vitreous body and cocommittent suction and replacement with a balance salt infusion solution using automated technology has made vitreous surgery extremely safe and highly efficacious. Endoillumination is used at the time of microsurgery allowing high manueverability of surgical instrumentation within the globe. Ocular morbidity is minimal in vitreous surgery.

In summary. This patient has heredeofam-ilial amyloidosis with ocular complications of marked visual loss from vitreous amyloid opacification. Vitreous surgery successfully restored vision.

I wish to acknowledge Drs. David Katz and Chanda Bewtra for their assistance with the pathological specimens.

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ORIGINAL ARTICLE

Clinical Applications of Signal-Averaged Electrocardiography In Patients After Myocardial Infarction

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INTRODUCTION

SUDDEN cardiac death afflicts over 400,000 people in the United States each year, most commonly secondary to sustained ventricular tachycardia or ventricular fibrillation.[1-2] The population at a greatest risk are those who have suffered a recent myocardial infarction. Studies indicate that mortality in this population from life-threatening arrhythmias is 10-15% over 2 years. Therefore, a challenge for the 90's is to develop tools that can identify patients at high risk prior to sudden cardiac death.

The signal-averaged electrocardiogram appears to be one of the most promising of those tools. In brief, it is an amplified high resolution composite of 200 to 400 normal QRS signals. Signal-averaging reduces random noise that contaminates the surface electrocardiogram. The steps involved in obtaining signal-averaged electrocardiograms include: recording, digitization, averaging, amplification and filtering. Surface leads to represent X, Y, and Z axes are recorded. After signal averaging, the leads are combined into a vector magnitude ✓ $x^2+y^2+z^2$, a measure that sums high frequency information contained in all leads. The process is automated and takes about 15 minutes to perform. (Figure 1)

Low amplitude, high frequency signals (late potentials, arrow, figure 1) are found in the border zone separating the scar of a previous myocardial infarction from normal tissue. This area is composed of strands of normal myocardial tissues interspersed with interstitial fibrosis which forms an insulating boundary and it slows the fragments the wave of electrical depolarization as it sweeps through ventricular myocardium. Thus, the border zone appears to be the actual substrate for reentry tachycardia and the source of late potentials.

The definition and measurement of late potentials have not been completely standardized and are dependent on the type of machines and filters used. Representative criteria for an abnormal signal-averaged electrocardiogram include: 1) a filtered QRS complex greater than 114 msec, 2) low amplitude terminal forces less than 20 uV during the last 40 msec of the QRS and 3) the presence of a low amplitude (less than 40 uv) high frequency signal (late potential greater than 38 msec[3]. However, investigators in Oklahoma[4] have correctly identified that signal-averaged electrocardiograms form a spectrum and should not be simply classified as normal or abnormal but should also be placed in the context of diminished left ventricular function and high grade ectopy.

Clinical Application of Signal Averaging After Myocardial Infarction

It has been shown that an abnormal signal-averaged electrocardiogram is present in 73-92% of patients who have life-threatening arrhythmias and prior myocardial infarctions.[5-6] In contrast, less than 6% of normal volunteers and 7-15% of patients with prior infarctions but without sustained ventricular tachycardia have

A flowchart showing a possible management strategy for a patient with nonsustained ventricular tachycardia occurring a few days after acute anterior myocardial infarction.

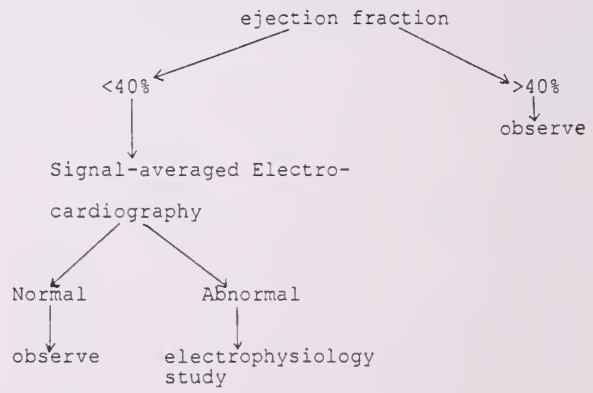

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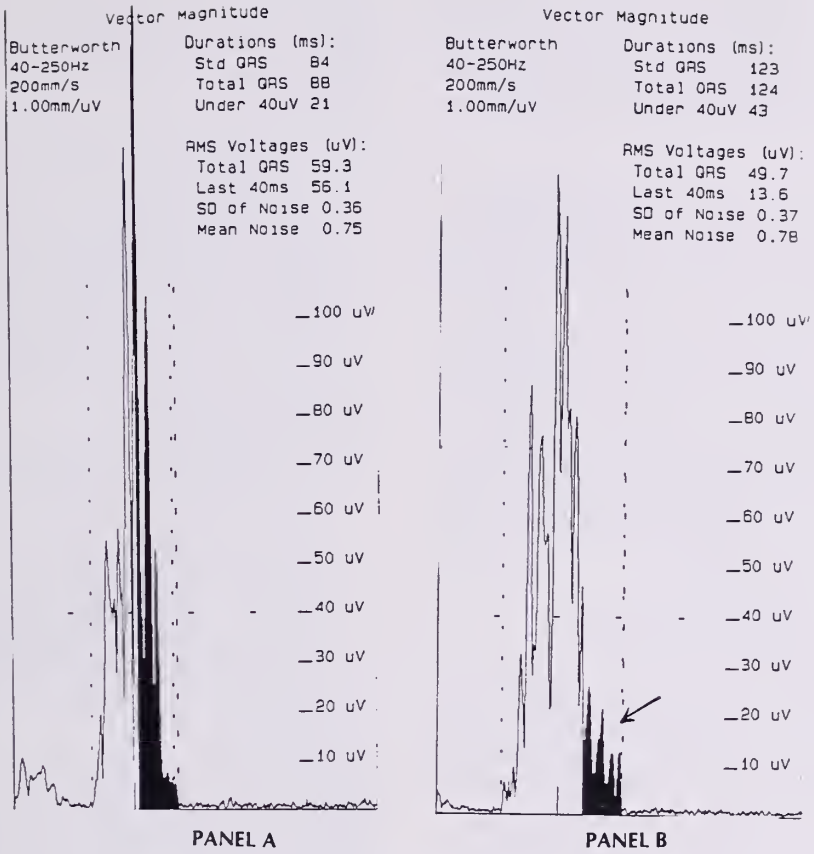
FIGURE1
Signal-averaged electrocardiogram



PANEL A
Was taken from a normal patient with terminal QRS of high ampiltude representing normal ventricular activation.

PANEL B
Was taken from a patient with spontaneous, sustained ventricular tachycardia. Note that this vector does not terminate abruptly but rather has a ong period of low amplitude, high frequency signals (denoted by narrow)

an abnormal signal-averaged electrocardiogram.[7-8] Abnormal signal-averaged electrocardiograms are common early post myocardial infarction (20-50%) but the prevalence decreases as the infarct heals. As you would expect, late potentials are seen more frequently in large transmural myocardial infarctions. As an isolated marker of sudden cardiac deaths, the signal-averaged electrocardiogram has adequate sensitivity (66-92%) and specificity (50-81%). However, the positive predictive value is low (4-29%)[9-11] in short term follow up. In other words, a patient with an abnormal signal-averaged electrocardiogram is at high risk, however, the majority of patients will be event-free during 1 to 2 years follow up. The possible reason is that these patients possess the potential for ventricular tachycardia, but without triggering factors, such as premature ventricular beats, altered autonomic tone, metabolic and ischemic factors, life-threatening ventricular arrhythmias do not occur. This suggests that tests such as electrophysiologic testing may be necessary to further stratify high risk patients. The negative predictive value, however, is excellent (96-99%). Further, both positive and negative predictive values improve when combined with left ventricular systolic function and presence of complex ventricular ectopy. Kuchar et al[12] found that an ejection fraction less than 40%, nonsustained ventricular tachycardia and an abnormal signal-averaged electrocardiogram identified a group of patients with 34 times more likely to suffer an arrhythmic event than a group who suffered a myocardial infarction but whose studies were more normal over a follow-up period of 14 months. Only 4% of patients with significant left ventricular dysfunction but a normal signal-averaged electrocardiogram suffered life-threatening arrythmias during the

same time frame. Results of multivariate analysis[13] show that risk stratification based on high resolution electrocardiogram is a powerful independent predictor of risk compared to tradition risk factors such as a low ejection fraction, complex ventricular ectopy, ventricular aneuysm and multiple stenosed coronary arteries.

Optimum Time to Acquire Signal Averaged Electrocardiograms after Myocardial Infarction

The optimum time after myocardial infarction for recording high resolution electrocardiograms has not been established. In a study by El-Sherif et al[14], abnormal signal-averaged electrocardiography obtained during the acute phase of myocardial infarction (24-48 hours) did not predict late ventricular tachyarrhythmias. It is thus reasonable to suggest that the optimum time window for obtaining a signal-averaged electrocardiogram is between 6 and 14 days after myocardial infarction.

Effects Of Acute Revascularization On Late Potentials

Various studies showed that thrombolytic therapy decreased the incidence of late potentials.[15-16] Vatterott et al[17] evaluated the relationship of late potentials and infarct related artery patency after acute myocardial infarction and found that signal-averaged electrocardiograms were positive in only 28% of patients with an open artery following their first infarction, in contrast to 61% if a closed artery was found. Therefore, an open artery seems to be an important predictor of negative signal-averaged electrocardiograms. Malik et al[18] showed that the presence of a closed artery, a depressed left ventricular function and a history of prior infarction predicted along term risks of cardiac deaths and ventricular tachycardia, but the presence of late potentials was not useful. It seems that late potentials are associated to artery occlusion and they do predict early deaths with infarction related closed artery.

The effect of angioplasty on late potentials is shown in a recent study[19] which indicates that the incidence of late potentials markedly decreases in patients with successful angioplasty after myocardial infarction with an occluded infarct artery. The mechanism by which the signal-averaged electrocardiography improves is unclear, but may be related to improvement of ventricular remodelling and prevention of thinning of myocardium. Survival benefit is unclear and a large, prospective trial can address that eventually.

Signal Averaging After Myocardial Infarction

A paractial question arises subsequently: Should signal-averaged electrocardiograms be obtained on all patients following myocardial infarction? Currently, there are two approaches: (see flowchart)

A. In patients who have a large myocardial infarction (ejection fraction less than 40%) especially if they have nonsustained ventricular tachycardia occurring a few days after myocardial infarction, a signal-averaged electrocardiogram should be considered. If the signal-averaged electrocardiogram is positive, one may further consider further evaluation such as electrophysiological studies.

B. Another school deems it necessary to perform signal-averaging on every patient following myocardial infarction, as the signal-averaged electrocardiography is an independent risk factor for future cardiac events and a substantial number of patients who die suddenly may not have markedly diminished ejection fraction or abnormal findings on 24 hour ambulatory monitor.

There are not enough data in the current literature to support one view over another. Current ongoing trials, like the Multicenter Unsustained Tachycardia Trial (MUSTT), may be able to give us insight into this question in future.

SUMMARY

In conclusion, signal-averaged electrocardiography is a useful, noninvasive technique to identify patients after myocardial infarction at risk for future arrhythmic events, especially in conjunction to existing tools, such as 24 hour ambulatory monitoring, echocardiography, nucleotide angiography and coronary angiography. It has a limited positive predictive value, but has an excellent negative predictive value. The optimum time to do signal-averaged electrocardiograms after myocardial infarction is unclear, 6 to 14 days after myocardial infarction has the highest sensitivity. Time domain analysis remains the most common method used to record late potentials. The definition of late potential and the scoring of a high resolution electrocardiogram as normal and abnormal have not yet been resolved. The criteria proposed by the Task Force Committee of the European Society of Cardiology, the American Heart Association and the American College of Cardiology[3] (see introduction) should be observed at

present. Many studies on signal-averaging were done in the prethrombolytic era. In patients who have received thrombolytic therapy, the positive predicitve value of signal-averaged electrocardiograms has decreased. There are other limitations in applying signal averaging technique. The faster the ventricular tachycardia is induced in electrophysiological studies, the shorter is the late potential.[20] Thus, a faster tachycardia which causes sudden cardiac death may not be detected by late potentials. The management strategies for patients who have abnormal signal-averaged electrocardiograms after myocardial infarction have not be defined. One should note that any management strategy has to prove that it improves prognosis. More prospective, randomized clinical trials are required to address these issues.

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PERINATAL PAGE

Is There Safety In A Home Delivery?

BRUCE E. TAYLOR, M.D.

WITH the recent hearing at the State Health Department where home deliveries were discussed, the legalization of home deliveries done by lay midwives was addressed. It was vetoed by a vote of 10 to 1. There are many variables that were taken into account including the committees own personal experience in making that decision. It is now up to Dr. Horton and/or the legislature to decide if it will be addressed in the upcoming legislative session. But what are the facts that were used to make this decision? To hear the proponents for lay midwives, it is a wonder that more of us are not doing home deliveries because it is reported as being safer.

My grandfather used to do home deliveries when he practiced in West Point, Nebraska. In that time it was easier to transport the physician to the home, than the family or patient to the hospital. He would often take his horse and buggy out of town to oversee the birth. In those days there were no monitors or IV's and little pain medicine except alcohol. As medicine and transportation became more advanced, the women came to hospitals to have babies because they thought it was "safer" in case complications arose.

Today we are highly technical with multiple monitors, bells and whistles making sure that both patients do well. These improvements brought some depersonalization of medicine and many women in labor seemed to be ignored. The physician and nurse often talked to each other trying to interpret the monitor and decide what was best for the patient and infant, usually not taking into consideration what the mother herself may have desired. Mothers in labor demanded less intervention and more of a "home" like setting so that she could share the birthing experience with her partner, children and friends. Birthing rooms and birthing centers have been the hospitals answer to where patients could be pampered in a home-like setting while making the sterile atmosphere of the hospital less intimidating.

Now the lay push back to home is stronger because of their perceived safety of home deliveries compared to the high rate of cesarean delivery in many of our hospitals. At home the mother can do what she wants and there is little medical intervention. It can all be accomplished **"naturally"**. Is a home delivery really safer for the mother and is the infant at any higher risk? These were the premises that intrigued me. Since most home deliveries involve low-risk term pregnancies, one needs to compare these to hospital low-risk term infants.

Somewhat ignored or bypassed thoughts are the following:

1. Is there a state mortality/stillborn rate for term pregnancies who are low-risk?
2. What is the hospitals infant mortality rate for term pregnancies excluding physical and/or genetic defects that are live threatening?
3. Are the chances of having a live baby upon admission to the hospital a guarantee that one should have a live infant delivered?
4. Do C-sections save lives, maternal or infant, or are the maternal complications worse?
5. What are the number of deliveries done in the home by lay midwives and their neonatal death rate?
6. Are we comparing apples to apples or to oranges?
7. Does it really make a difference what we think or believe to be the best for the mother or infant?
8. If banned, will home deliveries just go underground and the problem still be present?
9. Would allowing Medicaid patients the advantage of a lay midwife service alleviate the problem of getting them into medical offices, as this is currently difficult at best?
10. What are the rights of the infant in a home delivery?

These are some of the questions that should be brought to the legislature in the forthcoming sessions. I have my bias and beliefs but the lay people are the ones that take the time to lobby, because we are too busy in our practice to push for what is safer, and take mother and baby both into perspective. For this reason, I decided to review some of the literature supplied by the proponents

of lay midwives that was supplied to the health department on the midwifery issue.

First, attempting to research home birth safety is not a simple undertaking. There are many variables that make recording or data collection almost impossible. Most state birth certificates do not have an area that indicates if this was a planned home delivery, unexpected home delivery, or a home delivery transferred to the hospital. Other questions that arise concern prenatal care. Was the infant delivered allowed good prenatal care? And what are the qualifications of the person attending the delivery? These statistics would be an asset to compare apples to apples.

Second, when one tries to compare neonatal mortality rates of home deliveries to hospital deliveries, there is little acknowledgment that home deliveries were the LOW-RISK women to start with. They are usually multiples (who usually deliver easier the 2nd, 3rd or . . . time). Thus, they usually have a tested pelvis. Hospital deliveries also involve the preterm pregnancies, multiple gestations and maternal complications that could lead to higher mortality rates.

In regard to neonatal mortality, in a combined study of 7,114 planned/attended North American Home Births the crude neonatal mortality rate was 2.8/1000, (which is great!). However the rate for the United States in 1986 was 6.7/1000 (not bad). However, the rate for 1,199 planned home births attended by "non Missouri Midwives Association midwives and others" was 10/1000 (not good!).[1] In Michigan the neonatal mortality rate for infants greater than 2500 grams born at home during the period from 1975-1979, the average rate was 3.94/1000 as compared to 2.41/1000 in the hospital population.[2] (Hey this is better).

The Peel Report, presented in 1970 in Great Britain, argued for 100% hospital confinement and had a profound effect on the number of home births. After this report, the home birth rate dropped from 13% to 1.2% in 10 years.[1] (Maybe the English do know something about medical care.) It must also be argued that in the British literature, home birth statistics do NOT include those births which began as a home birth but were transferred to the hospital in labor. These transfers may falsely lower the rate of home birth mortality, as such transfers were associated with a much greater mortality rate.[3]

In Australia, recent studies of Woodcock (1990), and Crotty (1990) the perinatal mortality rates of planned home births was 16.2 and 10.1 per thousand respectively. For low risk women this is markedly higher than one should anticipate.[1] The Netherlands, is a country with a high home birth rate by midwives. This may not be because midwifes are better. An often ignored fact is that Dutch private insurance does NOT cover specialized physicians unless there are medical indications or there is not midwife in the district. If patients want physician care, they must pay for it themselves, "In other words, the Dutch maternity care system is midwife-centered."[1]

I checked the stillborn rate on term pregnancies at a local hospital. There they reported only one term stillborn in the last 1350 deliveries (.74/1000). This is lower than what was reported by lay midwife advocates. Therefore it must be safer to deliver at a hospital setting.

One last flaw perpetrated on the community is that "midwives are sued less frequently than physicians, and their malpractice insurance costs less. While the first premise is true, it may be related to the deep pocket theory and availability of insurance. In 1987 the average premium for a physician delivering babies was $37,000; for a midwife, malpractice insurance cost $3,500. This difference greatly contributes to the lower cost of midwifery care."[4] In reality, it is almost impossible to obtain independent malpractice insurance for lay midwives, as it is not available for home deliveries. "Robert Keszler, a senior special investigator for California's state medical board, has investigated 300 midwife-assisted births resulting in dead or brain-damaged babies, and he believes that almost all of them could have been avoided."[6]

I don't mean that there are not good lay midwives out there, but there must be strict guidelines for medical care and accountability for not following the rules, or the laws. I applaud the recent decision by the Health Department recommending limitations on home births. If a few people will not look out for their own or their unborn child's best interest, then the State must step in and make it safe to be born in Nebraska.

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COMMUNICATION

Professional Courtesy - Ethics and the Law In The Medical Treatment of Physicians and their Families

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A majority of medical schools are reported to have one or more courses in medical ethics and a few continuing medical education courses or meetings are reported to deal to some extent with medical ethics matters.[1] However, there appears to be a very large number of practicing physicians who do not follow the old time (pre-Medicare) practice of professional courtesy or the more recent opinion of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws of the American Medical Association. It is also noted that the Medicare Regulations (which have the full force of Federal Law) are very specific about some charging practices which were formerly considered to be purely courtesy or ethical matters.

The ethics, courtesy and legal aspects of providing and charging for medical care services to another physician and his family need to be well understood by all physicians. Widespread differences in handling this matter among physicians as a group and even different methods at different times by the same physician suggests that this whole matter is not widely understood and that a very large number of physicians are in violation of courtesy or ethical standards and also the law pertaining to the matter.

The 1955 AMA Code of Ethics is not contained in the current version of the Code, published in 1992 under the title Code of Medical Ethics: Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association. Current Opinions does not address the issue of professional courtesy, defined as "the provision of care to other physicians and their families free of charge or at a reduced fee". However, the Council on Ethical and Judicial Affairs (formerly the Judicial Council) does have a policy on the routine waiver or forgiveness of insurance deductibles and co-payments.

The AMA Principles of Medical Ethics adopted by the House of Delegates in 1980 is a revision of the older Code adopted in 1957 and does not specifically address the matter of courtesy or charging practices in the care of another physician and his family who are patients.

Reports C and D of the Council on Ethical and Judicial affairs presented to the House of Delegates at the annual meeting in 1993 were considered to be informational and were filed, as is the custom with such reports.[2] The reports do reflect policy and it is expected that all members will comply, or follow the advice given in the opinion.

Informational material from the AMA and private insurance industry is silent on the matters of definition of immediate family and also how to handle the charges (if any) in the care of a colleague (and his immediate family) who is a partner or a member of the same corporate practice group. This may be a close call for some when insurance benefits are involved, as they usually are. By definition, professional courtesy is a no charge. Insurance deserves no consideration here. Certainly courtesy would be ethical and legal. If there is no charge, then there is no expense and if there is no expense, there is no benefit from private or governmental sources. Providing medical care to an associate, his or her spouse and family is a privilege, an honor and a compliment.

With respect to providing medical care to other physicians (and their immediate families) with whom one is not associated in practice, the recent opinions of the AMA, the Medicare law and the private insurance industry are in general agreement as follows:

1. Physicians generally should not treat themselves or members of their immediate family (with a very few obvious exceptions) for many obvious reasons.[3] There is therefor no reason for charging, billing insurance companies or governmental agencies nor any question of unethical, discourteous behavior, or illegality. If a charge is made to an insurance company or governmental agency in such cases,

that would be considered to be fraud and legal prosecution with severe penalties could follow.

2. Physicians may ethically and legally charge other physicians and their families for medical care and services. It is apparently very widespread practice for the treating physician to take an assignment of insurance or Medicare benefits in such cases and to accept the insurance or Medicare benefits as full payment for the services. This is not legal for Medicare or private insurance and is not in accordance with AMA policy. Routine forgiveness of deductibles and coinsurance is specifically addressed as being illegal by Medicare law.[4] The part B carrier has no discretion to alter the regulations. Deductibles and coinsurance cannot be forgiven as a professional courtesy.[4] Ordinarily they may be forgiven only in cases of financial hardship or when repeated sincere efforts to collect are unsuccessful. AMA Opinions clearly state that routine forgiveness of deductibles and copayments may be considered fraud under federal and state law.[2] Private insurance companies believe that their contracts which call for deductibles and/or coinsurance should be enforced and considered in the same way as spelled out more specifically in Medicare law. They believe that waiving such payments does not then reveal to them what the real charge has been, that it is often inflated, and it adds significantly to the cost of health care coverage, that it encourages over-utilization of services and procedures and is often used as a ploy to attract more patients.[5]

3. Medicare regulations regarding charges for services provided to his or her immediate relatives have been sent to all physicians and should be reviewed carefully again. If lost or misplaced, any Part B carrier will provide a copy on request. In general, an immediate relative is a spouse, child, sibling, parent, grandparent or grandchild. Also included are the spouse's parents and siblings (but not the siblings' spouses and children). Medicare payment is also excluded for care or services to patients who share a common abode with the treating physician as a single family unit. Examples are full-time employed, live-in maids, butlers and chauffeurs.[6] Immediate relatives are not defined by AMA or private insurance contracts but both intend that physicians should follow the Medicare definitions.

Almost all physicians carry some medical insurance. This would be private insurance prior to Medicare eligibility. It could be personal private/family insurance, Association group insurance such as through AMA, ACP, AAFP, etc. or employer/employee insurance in a general or professional corporation. In all cases the physician or family patient should be treated the same as all other patients in charges, assignment of insurance benefits and collection of deductibles and coinsurance. Nearly all physicians who become patients surely desire and expect such treatment in financial matters.

Many physicians carry medical expense insurance with a relatively high deductible such as $500 to 1500 or even higher. Such coverage has considerably lower premiums. Even if the usual and customary charges do not reach the deductible level, the physician/family patient should be charged and billed and expected to pay for services. He will have saved more than enough in premiums over the years to pay for the deductibles.

Many physicians do not elect to take Medicare Part B coverage although that is automatic unless the physician notified Medicare to the contrary. Again, this does not relieve them from the responsibility and courtesy of paying their own way.

Most eligible physicians do have Part B coverage. Professional courtesy would suggest that an assignment of benefits be taken and a bill sent for the deductible and coinsurance.

Many physicians carry Medicare supplemental insurance of some kind which will cover most of the deductible and coinsurance charges, only rarely all of them. Acceptance of assignment of these benefits is more optional as many treating physicians do not send statements to secondary carriers. It would be a courtesy.

Many physicians and others do not believe it saves any money and usually costs more to pay premiums on the supplemental coverage than to pay the deductible and insurance out of pocket. Many examples could be cited. Some people believe in carrying lots of insurance and others prefer to carry the minimum. Certainly everyone should have medical expense insurance in the catastrophic range, above $2 to 5 thousand, for example.

In general, it is better not to make any charge or send any bill for the care of another physician or his family, OR make your usual and customary charge. Accept assignment of benefits and bill the patient for deductibles and coinsurance the same as you do for all other patients.

In general, do not bill Medicare or an insurance company for taking care of your family or your partner's spouse and family. That is professional courtesy and will be rewarded.

BIBLIOGRAPHY

1. Personal communication from AMA Medical Ethics and Health Policy, Health Law Division, August 31, 1993.
2. Report C of Council on Ethical and Judicial Affairs, AMA House of Delegates annual meeting, 1993.
3. Report D (same).
4. Personal communication from Medical Director of a Medicare Part B Carrier, August 24, 1993.
5. Personal communication from one of the largest private health insurance companies, August 23, 1993.
6. Medicare Regulations as revised, April, 1992.

EDITOR'S NOTE

Dr. Long was President of ASIM 1968-1969 and Delegate to the AMA House of Delegates 1980-1984. He is Associate Clinical Professor of Internal Medicine at the University of Nebraska College of Medicine and a Fellow of the American College of Physicians. He was Associate Medical Director and Consultant on Medicare for Mutual of Omaha Insurance Company from 1966 to 1989. He has been in the private practice of Internal Medicine in Omaha since 1947.

ASK A LAWYER

1. **When may a minor consent to medical treatment?**

The rule in Nebraska is that a minor (persons under 19 years of age) cannot give consent. A health care provider must secure the consent of the minor's parent or guardian before providing treatment. However, there are several exceptions to this rule. Neb. Rev. Stat. § 71-504 allows a minor to consent to examination and treatment of venereal disease, including prevention of such a disease, by prescribing birth control. If the patient is an emancipated minor (one who, although below the age of majority, has assumed the lifestyle and responsibilities of an adult), they are considered legal adults and may consent to treatment. Whether or not a particular minor is emancipated is a factual question depending on the person's age, maturity, economic independence, general adult conduct, and freedom from parental control. Consent is also not required when emergency treatment is necessary.

2. **Is there an age below which a patient's right to confidentiality may be violated without concern for legal consequence?**

Nebraska statutes do not specifically distinguish between minors and adults with respect to confidentiality. When there is no statute or case that specifies who may consent to release of confidential medical information on behalf of a minor patient, the treating physician should follow the general rule and secure consent from the minor's parent or guardian. In cases when a minor is authorized to consent to treatment, such as treatment for venereal disease, it is not clear whether that minor can also consent to a release of confidential information. However, if the minor has been emancipated and is considered a legal adult, presumably he or she could consent to a release of information. A parent or guardian stands in the place of the minor with respect to confidentiality, and thus the physician should normally feel free to discuss the minor's medical conditions with the parent or guardian except for the venereal disease exception discussed above.

***

"Ask a Lawyer' is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen Jr. with the assistance of UNL College of Law student Jane Evers of the Cline Williams office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

COMING MEETINGS

UNIVERSITY OF NEBRASKA MEDICAL CENTER MEDICAL EDUCAATION

SUNDAY-FRIDAY, MARCH 6-11, 1994 — 14th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MONDAY, MARCH 14, 1994 — Heartland Risk Reduction Society Meeting, Dinner/Program (6:30-9:00 p.m.), Omaha, Nebraska. Target Audience: Health care providers who treat patients with atherosclerotic vascular diseases. Fee: $10.00.

11 DAYS, MARCH 14-25, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY - SATURDAY, APRIL 14-16, 1994 — 2nd Annual Diagnostic Dilemmas in Women's Health Care, Marriott Hotel, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Fee: $200.

11 DAYS, APRIL 18-29, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY-FRIDAY, JUNE 12-15, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Obstetrics and Gynecology, Oncology/Hematology & Researchers.

THURSDAY-SATURDAY, JULY 14-16, 1994 — 1994 National Conference on Family Violence: Research and Practice, Holiday Inn Centre, Omaha, Nebraska. Target Audience: Multidisciplinary (health professionals, sociologists, criminal justice)

TUESDAY-FRIDAY, JULY 19-22, 1994 — Pan Pacific Lymphoma Conference, The Ritz Carlton - Mauna Lani, Kohala Coast, Hawaii. Target Audience: Oncology/Hematology & Researchers.

FRIDAY-SUNDAY, AUGUST 19-21, 1994 — Imaging and Breast Cancer, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians.

MONDAY-SATURDAY, SEPTEMBER 19-24, 1994 — Emergency Medicine Review, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

MONDAY-SATURDAY, OCTOBER 3-8, 1994 — Emergency Medicine Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

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ANNUAL SESSION - House of Delegates, April 28-May 1, 1994, Marriott Hotel, Omaha.

FALL SESSION — House of Delegates, September 15-17, 1994, Cornhusker Hotel, Lincoln.

CREIGHTON UNIVERSITY

MARCH 5-6, 1994— Fourth Annual: Anesthesiology Conference - Health Care and Reform - Marriott Hotel, Omaha, NE.

MARCH 7, 1994 — Obstetrical Complications - OB Outreach Program at Offutt Air Base, Omaha, NE.

MARCH 12, 1994 — Colon and Rectal Diseases Conference - Embassy Suites, Omaha, NE.

APRIL 3-9, 1994— Anesthesiology Review Course - Professional Seminars - Orlando, FL.

APRIL 4, 1994 — Medical Complications - OB Outreach Program at Offutt Air Base, Omaha, NE.

APRIL 15, 1994 — Distinguished Lecture Series - Henry J. Mankin, M.D. - St. Joseph Hospital Seminar Room.

APRIL 22-23, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

MAY 2, 1994 — Abruptio Placenta - OB Outreach Program at Offutt Air Base, Omaha, NE.

MAY 19-22, 1994 — A Review of Orthopaedics and Orthopaedic Pathology - Criss II Building, Creighton University, Omaha, NE.

MAY 27-29, 1994 — Family Medicine Update, Okoboji, IA.

JUNE 6, 1994 — Medical Therapy of the Fetus - OB Outreach Program at Offutt Air Base, Omaha, NE.

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THURSDAY-FRIDAY, APRIL 21-22, 1994 — Symposium On Obstetrics & Gynecology, Location: St. Louis, Missouri.

FRIDAY-SUNDAY, JUNE 24-26, 1994 — Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862 Interstate, (314) 362-6893 In Missouri, FAX (314) 362-1087.

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THURSDAY, JUNE 17, 1993 • State of the Art Clinical Symposium on Allergic Diseases, Location: The Ritz-Carlton Hotel, St. Louis, Missouri, Program Chairman: Phillip E. Korenblat, M.D.

FRIDAY-SATURDAY, September 10-12, 1993 • Frontiers In Endosurgery: Advances in Endourological Techniques and Technology, Location: Washington University Medical Center, St. Louis, Missouri, 18.5 credit hours AMA Category 1, Program Chairmen: Ralph V. Clayman, M.D. and Elspeth McDougall, M.D.

FRIDAY-SATURDAY, SEPTEMBER 17-18, 1993 • Physician Executive Leadership, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairmen: Walter F. Ballinger, M.D. and James Hepner, M.D.

SATURDAY, SEPTEMBER 18, 1993 • Suicide, Location: St. Louis, Missouri.

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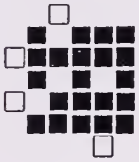

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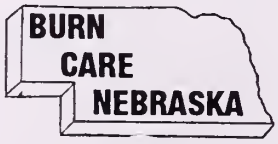

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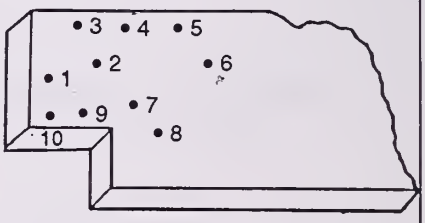

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Nebraska Medical Journal

A NEW ERA OF EXCELLENCE IN CANCER CARE

Treating Cancer Takes Teamwork

Today, leading cancer experts are combining sophisticated treatment modalities — surgery, chemotherapy and radiation therapy — with increasingly better results. This type of care requires new levels of collaboration between surgeons, medical oncologists, radiation oncologists, radiologists, pathologists and other health care professionals.

The Methodist Cancer Center was designed from the ground up to foster an interdisciplinary approach to cancer care. ***In this special setting, up to two dozen doctors contribute their expertise and understanding of cancer care. They confer weekly to develop comprehensive treatment plans for people who have been diagnosed with cancer.***

Interdisciplinary care teams, composed of specialty physicians, oncology nurses, pharmacists, therapists, dietitians, counselors, social workers and chaplains and guided by a medical oncologist, provide care at the Methodist Cancer Center. They coordinate services to meet the patient's home health care needs and meet regularly to assess patient progress. The patient's primary physician receives regular updates and participates in follow-up care.

For more information on the services available through the Methodist Cancer Center or to refer a patient, call the Physicians' Priority Line, 1-800-627-6363.

"The Methodist Cancer Center will enhance patient care by integrating multiple cancer treatment specialists and services in a single location."

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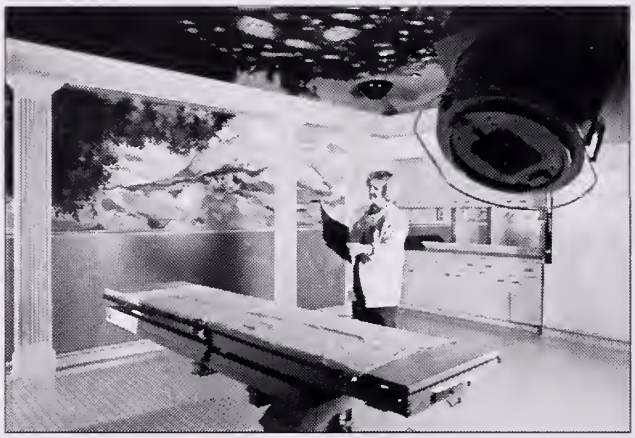

Living with the diagnosis of cancer and its treatment has a profound impact on patients' physical, emotional, social and spiritual needs. Storz Cancer Institute provides a multidisciplinary approach to assist physicians, patients and families in identifying and dealing with these special concerns.

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Storz Cancer Institute has installed the region's first linear accelerator with a multileaf collimator. This technology, along with advanced treatment planning capabilities, will allow Clarkson radiation oncologists to offer the only conformal radiation therapy services available in the region.

The idea of three dimensional conformal therapy is to deliver higher radiation doses to tumors while limiting the dose to adjacent normal tissues. The goal of this technology is to increase the likelihood of curing localized tumors while limiting side effects from radiation treatments.

Storz Cancer Institute has developed research affiliations with Christie Hospital in Manchester, England, and ADAC Treatment Planning Systems to further the conformal therapy program. Christie Hospital is considered one of the leaders in multileaf collimator conformal therapy technology.

For more information, call the Storz Cancer Institute at 402-552-3844 or call MD Source toll-free at 1-800-552-5552.

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The Nebraska Medical Journal

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Breast of chicken

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Best of pork

3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques. According to new 1991 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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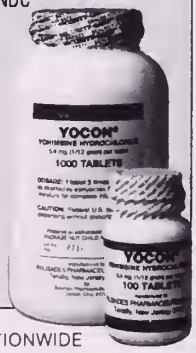

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AMA NEWS NOTES

'SINGLE-PAYER APPROACH EMPHASIZES COST, NOT QUALITY CARE IN REFORM'

A single-payer approach to system reform would be "less responsive to patient needs," the AMA said at a Feb. 1 congressional hearing.

AMA Board Chair Lonnie R. Bristow, MD, shared this and other AMA concerns during a hearing of the subcommittee on health and the environment of the House Energy and Commerce Committee.

The panel looked at proposed single payer legislation, HR 1200, known to many as the "McDermott Bill" for its sponsor Rep. Jim McDermott (D, Wash.).

His proposal to achieve universal coverage calls for a government-administered and financed health care system. It is backed by the largest voting bloc of House Democrats, and is sponsored in the Senate by Paul Wellstone (D, Minn.).

At the hearing, Dr. Bristow said existing government-sponsored single-payer systems too often base treatment decisions on cost rather than quality of care.

"While the single-payer approach would achieve our goal of universal coverage, we cannot support the strict global budgets and price controls to programs that hold patients' lives and welfare in the balance."

A private, market-based system would build on and improve the existing employer-based system. This, Dr. Bristow said, is "a more cost-effective, realistic way of achieving universal coverage and safeguarding quality."

"Our approach would slow the rate of growth in health care spending by increasing competition in the marketplace, requiring employers and insurers to offer people a choice of health plans and ways of financing care. It also encourages cost-conscious patient decision-making."

Physicians will not support reform proposals that do not permit doctors to negotiate with federal and state governments on fee schedules, patient care and benefits decisions, Dr. Bristow said.

"Our vision supports a negotiated goals approach in which physicians would sit down at the table with state or federal representatives to establish reasonable spending targets that account for demographics, disease, technology and demand factors."

(continued on page 10A)

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AMA NEWS NOTES

(continued from page 8A)

Patients, he stressed, want physicians to work as their advocates, "not under the shadow of a health plan that has financial conflict of interest with providing care."

"Meaningful choice will not be realized if cost pressures ultimately force patients into low-end managed care plans that diminish patient choice, access to specialist care and quality."

McDermott said he would support the idea of physician negotiations under a single-payer system.

* * *

CONGRESS WARNED THAT REFORM MUST NOT HARM QUALITY NOR PATIENTS

Physicians must have a larger role in the new health care arena and direct involvement on quality-of-care decisions.

The AMA delivered that message to a congressional panel Feb. 10, strongly urging Congress to clarify antitrust laws.

(continued on page 15A)

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AMA NEWS NOTES

(continued from page 10A)

Charles P. Duvall, MD, a member of the AMA's Council on Legislation, testified before the House and Labor Subcommittee on Labor-Management Relations, charged with listening to providers' perspectives on health system reform.

Dr. Duvall warned that current antitrust laws and enforcement activities will have a "chilling effect" under a reformed health system dominated by large corporate entities and government bureaucrats.

"Physicians must be able to compete with major corporate players, who face far fewer legal obstacles in forming health plans.

"We have the knowledge and training that best qualifies us to be accountable for decisions concerning the management and delivery of optimal patient care."

Turning to medical education, Dr. Duvall stressed concern over physician workforce issues. He targeted several reform proposals now before Congress that seek to increase the number of primary care physicians and decrease the number of specialists.

(continued on page 94)

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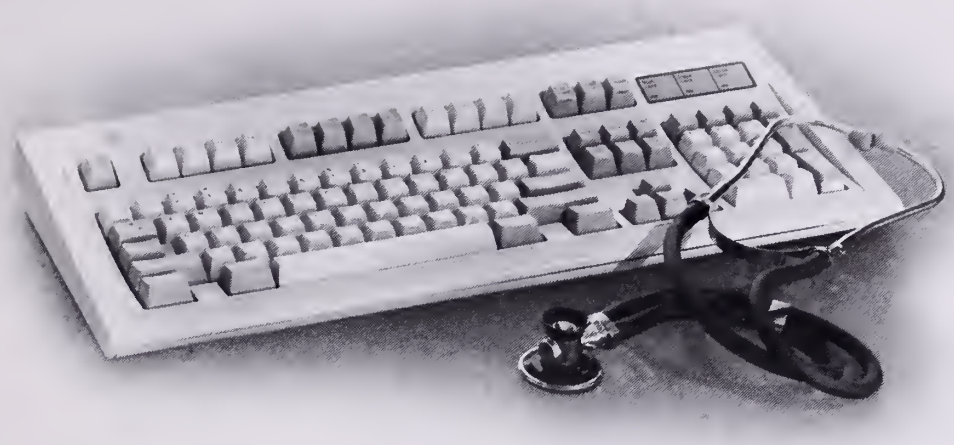

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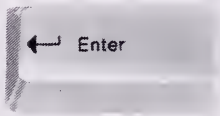

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PRESIDENT'S PAGE

Health System Reform

ROBERT F. SHAPIRO, M.D.

As your President, it is both a challenge and pleasurable duty to write the monthly "President's Page." Generally, they have been approximately 1500 word essays designed to raise questions rather than provide answers. Because writing does not come easy for me, they have required significant time and effort. This month, I get to take a rest. Here's how it happened.

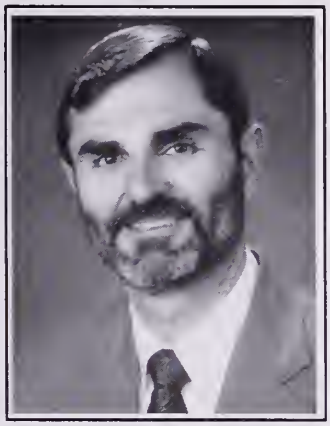
During 1991-1992, Dr. Philip Hofshire, an Omaha pediatric cardiologist, was the beneficiary of a wonderful opportunity to serve as a Robert Wood Johnson Fellow in Health Policy in Washington D.C. where he was able to pursue his intense interest in health policy.

After returning to Omaha, he persuaded the diverse, knowledgeable group of people you see in the Table of Contents, to write those articles about health care reform covering both the federal and state perspectives. (Since I don't think health care, itself, needs reform, I prefer to speak of health system reform, but let's not quibble.)

At this point, Dr. Hofshire, either sometime before or just after the articles were written, approached Dr. Gelber, our editor, and requested that the Journal devote an entire issue to this compendium of articles about health care reform.

A request for an entire issue is not simple. Your editor and the medical association board have to decide if there will be sufficient reader interest to warrant an entire issue, if the extra costs of this "fatter issue" are warranted, and if it wouldn't be wiser to "spread out" the material over several issues and still include scientific articles.

After extensive discussion and consideration of all options, we decided that the issue of health care reform is so timely, is intruding so heavily on people's thoughts, and the articles of such value, containing important facts and points of view that publishing as a single issue was justified.



Robert F. Shapiro, M.D.

I have read the articles several times. I pondered whether to attempt to critique them. I decided against it. Dr. Hofshire has provided an excellent editorial overview and concludes with cogent remarks about the future of health care.

The articles are written by state and federal public officials, academics, physicians, a hospital administrator, planners, insurance people, and a policy person. Their articles are rich in fact, express opinions, and reflect their biases. The views expressed do not always coincide with dominant physician viewpoints.

I have worked with may of these people on panels, on committees, and in work and study groups. The articles have not just been written on request. They are the products of genuine people providing their best input to help work through an important public issue. It is my belief that you will consider this issue useful and worthwhile. Go to it Dr. Hofshire.

I. EDITORIAL INTRODUCTION

Introduction

*PHILIP J. HOFSCHIRE, M.D.
President and CEO
Great Plains Physician Group

Dr. Hofschire was a Robert Wood Johnson Fellow in Health Policy in Washington, D.C. during 1991-1992. This non-partisan fellowship was initiated in 1973 to educate health care providers in reform and legislative issues. Dr. Hofschire is President and CEO of the Great Plains Physician Group.

INTRODUCTION

THESE are tumultuous and anxious times for health care providers. The specter of reform promises the dream of guaranteed access at a low cost while assuring quality. While most of us who practice medicine would applaud such an outcome, we have a genuine concern about the type of plan, its delivery system, and the mechanism of financing.

In an attempt to widen the knowledge base of our association, The Nebraska Medical Journal has devoted an entire issue to health care reform. We have chosen a wide variety of subjects; hopefully, each will reflect a different aspect of health reform. While we would like to be comprehensive, reform is a complex and gigantic issue; accordingly, a lengthy discussion was not possible in all articles.

Governor Ben Nelson has established two separate groups to formulate a plan for assuring health care for Nebraskans. These groups, the Blue Ribbon Coalition, and the Inter-Agency Commission have completed their individual plans and will be submitting their recommendations to the Governor.

Senator Bob Kerrey remains a leader for health care reform in our national government. His views are thoughtful and his knowledge is substantial. He will be an important avenue for us after formulation of either association or individual ideas.

Finally, these articles are written without political intent; they are not intended to support or debase any plan. They will hopefully be informative and serve as a resource for health issues that affect our patients and each of us as providers.

REFORM INITIATIVES

Interest in health care reform, both at a state and national level, has continued to increase. This interest recently culminated in the Health Security Act presentation by President Clinton. The state of Nebraska has spent nearly two years in the development of their own initiatives. Both the state and federal programs will be discussed in this section.

State

In January, 1992, Governor Ben Nelson, in response to Nebraskan's concerns about health costs and the large increases in state health care spending, established two separate committees to evaluate these issues. The Blue Ribbon Coalition to Study Health Care in Nebraska was formed of a wide band of 33 providers and consumers. The committee was co-chaired by Frank Barrett and Sister Norita Cooney.

The Inter-Agency Health Care Advisory Committee was chaired by Dr. Mark Horton and Senator Don Wesley and included representatives of the Departments of Public Institutions, Social Services, Education, Insurance and Aging.

The deliberations of the individual committees were sent to the Governor as a list of recommendations in October, 1993. While it is presently unknown whether there will be continuation of these task forces, Governor Nelson seems intent on developing a plan which is consistent with the thoughts and needs of all Nebraskans.

Both of the committees have several common characteristics which are also seen in President Clinton's Health Security Act. Access for all Nebraskans, establishment of quality standards for services, cost containment, flexibility of choice, innovation, and reorganization of financing are

*Address correspondence and reprint request to: Philip J. Hofschire, M.D., 44th and Dewey P.O. Box 3328, Omaha, NE 68103.

all common concerns. The Blue Ribbon Coalition developed a basic, comprehensive benefit package, whereas the Inter-Agency Committee did not. Neither group was specific on either costs of their plans or defined ways to finance them. Mr. Barrett will present the Blue Ribbon Coalition efforts.

FEDERAL

The health care reform package delivered by President Clinton seems a marriage of governmental regulation and free market competition. While such an approach tends to mollify most groups in the center of the debate, it leaves groups desirous of single payer systems or complete free market approaches without much enthusiasm.

The Republican response reported here is a plan of Senator John Chafee. While it is not the only Republican proposal, many feel it is the most mainline and supported by the center of the Republican party.

The CLINTON PLAN (Health Securities Act)

Universal Coverage and Employer Mandate

The backbone of this plan is universal coverage and employer mandating. Individuals would be required to enroll in a regional plan and have at least 80% of their premiums paid by their employers. Those failing to enroll would be assigned to a plan when they access medical care. Coverage would be guaranteed to all U.S. citizens and legal residents and could not be cancelled because of sickness, loss of jobs or moving to another state.

Insurance would be obtained through state created regional or corporate insurance purchasing alliances. Persons covered by Medicare, veterans and military personnel, and the Indian Health Service would remain separate, but Medicaid recipients and federal and state employees would be included.

Large corporations, with over 5,000 employees, could form their own "corporate alliance" but would have to provide the same benefit package that will be approved by a national benefit board. Failure to comply or a loss of employees to below 4,800 would require the company to join a regional alliance.

Benefit Package

A benefit package will be established by a seven member National Health Board. Benefits will include physician services, hospitalization, emergency services, mental health, substance abuse programs, family planning, hospice home care, outpatient prescription drugs, outpatient laboratory and rehab services, vision and hearing care, health education classes, and preventive dental services for children.

National Health Board

This seven member board would be appointed by the President and rival the Health and Human Services Department in power. The Board could set federal standards on quality and oversee the creation and administration of the regional alliances as well as the states themselves. The Board would interpret the benefit package and recommend changes to Congress and the President.

The Board would calculate and enforce health premium targets and have broad budgeting powers. It would also establish baseline budgets for health alliances in each state.

States

States must ensure access for all citizens to an approved health care plan. Each state must have at least one regional alliance in place by 1997 or establish a single payer system to be all inclusive. Medicare could be folded into the alliance as long as the benefit package is not altered. States can limit enrollment in high cost plans, set rates for health providers, and institute health planning laws.

States must establish a guaranty fund to provide financial assistance to health providers if a health plan becomes insolvent.

Health Plans

States would qualify health plans which would include HMO's, fee for service plans or hybrids. Each of the latter two would cost a greater amount.

States would follow federal rules to insure solvency. All plans would follow national plans that exclude plan termination, pre-existing condition clauses or imposition of pre-coverage waiting periods. States can force insurers to contract with designated specialty providers and academic centers of excellence.

Malpractice Reform

Alliance approved health plans would have to establish new alternative dispute resolution (ADR) models. Although patients would have to submit claims through this system initially, they could go to court if unsatisfied. A pilot program will also be implemented that establishes protection from malpractice claims for those physicians that conform to established practice guidelines.

Consumer Empowerment

Regional alliances would make public the cost of the individual health care plans and develop performance reports for each of these plans.

Medical Education

Federal funding of graduate medical education would be changed to assure that 50% of new physicians will be trained in primary care within the next 5 years. Health and Human Services would be responsible for establishing training position levels; failure to comply would bring denial of federal funding.

Underserved Areas

To improve access in rural and underserved areas, physicians will receive a $1,000 per month tax credit for the first five years of their practice. Nurse practitioners and physician assistants would receive credits of $500 per month.

New Benefits

Outpatient prescription drug benefits for Medicare recipients would be paid for by limiting Medicare spending growth and imposing higher costs for the elderly with high incomes. Home and community based care services for the elderly, disabled, and chronically ill will be established by the year 2000. This program will have premiums that are income based and funded by the federal government with additional assistance from the state.

Medicaid

Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) recipients would receive coverage from the alliances. Non-cash recipients would receive their coverage through their employer. Disproportionate share payments to hospitals that treat a heavy volume of uninsured patients would be halved.

The REPUBLICAN RESPONSE

Universal Coverage

Chafee's plan requires everyone to have insurance coverage and offers vouchers to low-income workers to buy it. While the plan requires the employers to offer workers insurance, it does not mandate that employers pay for it. There would be creation of insurance pools to make coverage more affordable to small business.

Benefit Package

Insurance plans would be subject to most of the same changes proposed by the Clinton plan. Coverage would take all applicants and guarantee both renewability and portability. Premiums would be risk adjusted and community rated. The plans would offer a standard benefit package similar to President Clinton's plan. It would cover all "medically necessary" services, including prescription drugs, preventive services, substance abuse treatment and care for severe mental illness.

Health Benefits Board

Similar to the National Health Board in concept, it would have markedly less power. The Commission would be appointed by the President and Congress and set up a comparable benefit package to President Clinton's initiative. Changes would need congressional approval on an annual up and down vote. Technology changes could be inserted within individual plans without governmental interference. All insured citizens would receive a "health security card" similar to the President's concept.

Medicaid

HHS would establish a federal payment based on historical data from Medicaid files. There would be an end to state-federal matching and the Medicaid recipients could be placed in managed care or other approved state plans.

Malpractice Reform

Republican malpractice reform centers on mandating non-binding alternative dispute resolution and capping non-economic damages. Providers who follow approved practice guidelines would have a presumptive defense against malpractice claims.

The Republican plan is rather incomplete in a variety of other areas. Many of these areas will be expanded in response to the President's plan.

SUMMARY

There are two major differences in both plans: one, is the mandating of employers to pay for the health care insurance of their employees in the President's plan, and two, the highly regulatory role of the National Health Board of the Clinton proposal.

While both plans have ideas for financing regarding administrative streamlining, elimination of waste, fraud and abuse, malpractice reform and decreasing Medicare and Medicaid spending, neither have proposed fiscally sound budgets on how to realistically pay for universal coverage without significantly raising taxes on the American public.

I. EDITORIAL INTRODUCTION

Health Reform: The Governor's Perspective

*GOVERNOR BEN NELSON
State Capitol
Lincoln, NE 68509

Governor Nelson is active in health care reform, and at his direction, the Blue Ribbon Commission and Interagency Commission were brought together in order to formulate a plan for the state in health care.

NOT unlike the rest of the nation, Nebraska's health care costs continue to skyrocket, eating into the discretionary spending of the state, as well as our families' and individuals' pocketbooks. And though federal legislation is being prepared to address problems in the health care industry, we are hopeful that the states will be afforded the opportunity to develop their own plans for solving health care problems. I have long believed that top-down, federal mandates rarely benefit the states and often add to the problems. We in Nebraska are best equipped, by working together, to develop solutions that will meet the needs of providers and citizens.

We have begun that process in Nebraska. I have appointed two groups to evaluate the specific needs and problems facing our citizens and health care providers. Comprised of citizens, health care providers and state officials, the groups have worked together to identify the uniquely Nebraskan, as well as universal problems of costs, delivery, and access.

We know that health care costs in Nebraska are projected to increase by 118% by the year 2000. Out-of-pocket expenditures for health care in Nebraska will increase at a similar rate. According to 1990 estimates, Nebraska ranked sixth in the nation for per-capita health care expenditures, with almost 13% of average family income spent on health care. These are alarming realities in a nation that already spends more for health care than any other industrialized nation.

Nebraska is feeling the effects of the health care challenges as Medicaid costs continue to eat away at our state budget. But Medicaid issues are only a reflection of the increases in costs and charges faced by all citizens. Health care reform, whether it occurs at the national or state level, must not only address these increases, but also must balance this issue with access to quality care.

It is estimated that about 155,000 Nebraskans under age 65 (11% of the population) did not have health insurance coverage during 1990; about 20% of those not covered were children. Most people have insurance provided to them by their employers. But while the unemployment rate in Nebraska has steadily declined, the percent of uninsured adults under age 65 has climbed. Insurers are also forced to make critical decisions as they face the need to increase their customer base to cover the increasing costs of claims. However, they must do so in a manner that is both affordable and allows them to remain solvent.

Any Nebraska solution must also address the issue of access in rural communities. Many of Nebraska's rural communities are facing a critical shortage of health care providers. We are fortunate to have dedicated health care practitioners in the state who combat professional isolation. But this is a difficult task in light of the lack of backup support in case of specialized emergencies, and long drives to emergency services and health care facilities, both of which must be overcome while maintaining high-quality services. As physicians retire and move, rural communities are finding it more and more difficult to recruit and retain qualified general practitioners (and virtually impossible to attract specialists). Even when physicians are able to establish viable practices in rural communities, they often must function without the support of

*Address correspondence and reprint request to: Governor Ben Nelson, State Capitol, Lincoln, NE 68509.

nurses and allied health professionals. A few examples of the types of professionals for which there is severe need includes nurses, physical therapists, occupational therapists, and radiation therapy technologists.

As governor, I recognize the physicians' need for compensation, quality of life, and access to medical facilities. I also understand the need to encourage more general practitioners to locate in our state. To encourage and assist rural youth to enter medical practice in rural communities, the State funds the Rural Health Opportunity Program (RHOP) and student loan programs. The program is helping Nebraska meet three fundamental goals: to educate our children; to provide opportunities that allow them to remain in their hometowns and rural communities; and to help fill the critical need for health care providers in rural Nebraska.

As we continue to analyze health care issues and develop solutions to problems facing Nebraska, I know I can count on your continued support and constructive comments in meeting these difficult and critical challenges.

II. HEALTH REFORM AT THE FEDERAL LEVEL

Top 10 Irrelevant Agruments in the Health Care Debate

*SENATOR BOB KERREY
United States Senate
Washington, D.C.

Senator Bob Kerrey is a junior senator from Nebraska who has been at the forefront of national health care reform. In a speech in the Senate chamber on February 8, Senator Bob Kerrey urged colleagues not to waste time debating irrelevant arguments in health-care reform. Kerrey presented a list of his "Top 10 Irrelevant Arguments in the Health-Care Debate." Among the 10: whether a crisis exists in health care (Kerrey noted that "we do not wait until the majority of Americans suffer a crisis to act"), and whether health-care reform should involve mandates (Kerrey noted that mandates are present in the current health-care structure). Kerrey's remarks follow.

MR. President, I would like to respond to some statements made earlier by the distinguished Republican leader and the distinguished senior Senator from New Mexico. They commended the courage of Robert Reischauer, the head of the Congressional Budget Office.

As the health care debate heats up during the next several months, we need to be honest with the American people. I have heard several arguments lately that I believe are misleading and do not contribute to an honest debate on health care. The arguments are irrelevant and do not begin to solve the health care problems facing our country. I have collected these into a top 10 list of irrelevant health care arguments.

1. IS THERE A HEALTH CARE CRISIS?

Whether or not there is a health care crisis is irrelevant. We do not wait until the majority of Americans suffer a crisis to act. If a constituent notifies me of a problem, I act on their behalf. For example, the mayor of Hastings informed me of a problem with an overly strict interpretation of an environmental regulation. I did not respond that I could not help him until a majority of cities face the same problem. For the city of Hastings, there is a crisis now. I have heard from many Nebraskans about health care problems. For them, there is a crisis. It does not matter to them whether there is a nationwide crisis. They need help now.

2. I AM FOR/AGAINST MANDATES TO PAY FOR HEALTH CARE.

This argument is also irrelevant. We already have mandates in place to pay for health care today. The idea that the American people are reading op-ed pieces either for or against mandates when I have an imposed 3 percent mandate on wages now is an indication of how politicians have been misleading the public. This mandate is called the part A FICA Medicare tax. Individuals and employers each pay 1.45 percent of payroll to finance health care.

3. I AM AGAINST NATIONAL HEALTH INSURANCE.

We currently have national health insurance. And there is a payroll tax used to fund it as discussed in No. 2 above. We call it Medicare, but it is national health insurance. You have to be 65 years of age to qualify. Understand, I am not advocating extending Medicare for everyone, but for politicians to stand up and say they are against national health insurance, while supporting Medicare, is a very misleading argument. It makes it difficult for us to reach the correct solution to the health care problem.

4. I AM AGAINST USING BROAD-BASED TAXES FOR HEALTH CARE.

Although the authors of virtually all the health reform plans, including President Clinton, have proclaimed their opposition to using broad-based taxes to pay for health care, the fact is we are already using broad-based taxes to pay for health care. We need to tell Americans that fully 30 percent of their income taxes are being used to finance Federal health care spending. Not only are individual income taxes being used, but corporate income tax, payroll taxes, and property taxes finance health care today. By stating that we don't want to use broad-based taxes to pay for health care, we are avoiding a very important question. How are we going to pay the bills?

*Address correspondence and reprint request to: Senator Bob Kerrey, United States Senate, Washington, D.C.

5. I DO NOT PAY FOR HEALTH CARE TODAY

Many individuals and companies believe that they do not pay for health care today simply because they do not purchase insurance. In reality, as I already discussed, because a great amount of tax dollars are used to pay for health care, everyone is paying for health care today. We need to have an honest discussion on how we should be paying for health care so that everyone understands how much and in what manner they are paying.

6. I AM AGAINST A GOVERNMENT TAKE OVER OF HEALTH CARE.

As is made clear by argument No. 4, there is already substantial Government involvement in health care. The Government paid $450 billion out of the $700 billion of non-out-of-pocket health care expenditures in the United States in 1993. The question we should be debating is, What is the proper role for the Government? That is the question we need to address.

7. UNINSURED AMERICANS ARE CAUSING THE HEALTH CARE PROBLEM.

We should not be focusing on the problem of the uninsured — the problem is that health care costs have risen to a point where you have to be insured for routine health services. The best example for me is that in 1974 and in 1976 when my children were born, I paid for the costs out-of-pocket. I did not have to be insured to have a baby. It now costs $6,500 for a 2-day normal delivery of a baby in Nebraska. The median family income in Nebraska is $18,000 per year — therefore it is a financial catastrophe to have a baby in Nebraska without health insurance. The problem is that the cost of health care has grown to a point where people of average means live in constant terror that they will have to encounter the health system. It is not just pre-existing conditions, it is not just the lack of portability, it is that the overall costs of health care have become extreme.

8. REFORMING THE HEALTH CARE SYSTEM WILL CAUSE RATIONING.

There is already rationing in today's health care system. The hardest thing we have to deal with in health care is that at some point we ration care. There are very few Americans that can afford the $175,000 that it costs, on average, to receive a bone marrow transplant for breast cancer. I heard earlier this week from clinical researchers and oncologists that rationing already exists when it comes to patients receiving the newest treatments. Both patients and insurers have to face the reality that certain procedures and treatments are very expensive and cannot be given to everyone. What we need to debate is how to set up a system where the resources are allocated in the fairest, most humane way.

9. I SUPPORT A PRICE COMPETITIVE HEALTH CARE MARKET.

Many today argue that the country's health care problems can be solved solely through the market. However, there have been so many interventions that there is no longer a competitive health care market. For example, there are licensing restrictions that limit the number and type of providers. Patent laws protect new drugs. The tax system subsidizes the purchase of health insurance and many health care industries are tax exempt. Although using the market can help us solve the current health care problems, we need to look more deeply at current practices that hinder competition.

10. ISSUING A HEALTH CARE CARD WILL GUARANTEE HIGH QUALITY CARE FOR EVERYONE.

I support simplified eligibility for health care; however, simply issuing a card will not guarantee high quality care. The ability to receive high quality care is tied to ability to generate wealth, both individually and as a country. We all know that individuals who are wealthy do not worry about high quality care because they have the personal resources to pay for it. What is true for the individual is true for the Nation. Our capacity as a nation to afford high quality care will, in the end, depend on our ability to generate additional wealth. We must continue to focus on education and job creation which improve our country's wealth as we work to reform the health care system.

In conclusion, I believe it is time to tell the truth to all Americans. When everyone is operating in an open and honest environment, we will be able to reform our health care system and begin to create a healthier America.

Mr. President, I essentially identify what I consider to be the top 10 irrelevant arguments on the issue of health care. The fact of the matter is that the American people say there is a crisis in health care.

We recently heard my latest irrelevant argument . . . is there not a crisis? There is not a crisis for us who have our health care taken care of, but for an increasing number of Americans, indeed a majority of Americans feel like they are on this thin ice where if almost anything happens in their life, they will find themselves medically indigent.

The most courageous individual in the health care debate right now is the President of the

United States who has introduced a very specific piece of legislation and has put himself at risk as a consequence and has indicated to all that there is only one indivisible principle that he has, only one principle he says that if it is not included in the legislation that he is going to veto it, and that is health care legislation must be 100 percent universal. That is to say that every single American has to be covered.

I am here to say that we have a lot of work to do to enact a piece of legislation. I thing the CBO report is useful; in fact, it does give us an indication of what can be on- and off-budget. I share those who say Mr. Reischauer was courageous in stating his honest opinion of the impact of the President's legislation. But if we are going to get universal coverage, if we are going to enact a piece of legislation, then we are going to have to stop all the irrelevant arguments that I hear over and over and over.

For example, one of the irrelevant arguments is, should we or should we not have a mandate? Mr. President, we already have a mandate in place. Every employer pays a tax of 1.45 percent of their payroll, every employee pays a tax of 1.45 percent of their wages. It is mandated and is in place right now. It goes for a part A Medicare, and guess what part A Medicare really is? It is national health insurance. The only catch is, you have to be 65 before you are eligible.

So if you walk down on the floor here and say you are against a mandate, if you walk to the floor and say you are against national health insurance, it must inescapably follow that you are against Medicare. That is not what is going on.

I hear people say. "I'm against a big Government takeover of health care." And $150 billion this year will be collected in taxes and used to pay for health care — Government health care. Mr. President, if you are against a big Government takeover of health care, then for gosh sakes, identify what part of the Government you want to stop; where do you want to get Government out?

I think there is an emerging consensus in this body that begins by saying that there is a crisis; that this system is broken and it needs to be fixed. I believe that there is a bipartisan consensus to do just that. The President of the United States has not polarized the debate by indicating that he is unwilling to compromise. Quite the opposite. He has merely said that he wants to be able to go to bed at night, as I do, secure in the knowledge that every single American is covered. We can do that, Mr. President, I believe by focusing on those things that are indeed broken.

I would like to suggest four things we need to fix in a couple of minutes and then I will let the distinguished Senator from Massachusetts jump in. He is looking at his watch. I will try to give him enough time to talk before the vote.

Mr. President, the four things to me are, number one, the insurance system is broken. Indeed, the President needs to be given a great deal of credit for bringing the insurance companies to the table and saying they are willing to fix pre-existing conditions, they are willing to end the problem of portability, they are willing to end the skimming going on today in the system, a system that provides an incentive only to insure those who are healthy. We need to fix what is wrong with the insurance system.

Second, our Medicaid system is broken, and I would identify that as the second most important thing we need to do.

Third, if we really want to move from a Government-controlled system, which we have today, to a more market-oriented system where individuals are more in control of making decisions about price and quality, then there are a number of things that we are going to have to change in our tax system.

Fourth, I believe there are a whole series of things that I identify as coming under the heading of accountability. Our system is unaccountable. We have an unaccountable system when we collect money in Washington; we have an unaccountable system when an individual finds themselves not able to get payment for something troubling them; we have a very unaccountable and difficult system.

I came here to say that I appreciate that the Republican leader and the distinguished senior Senator from New Mexico recognize the courage of Mr. Reischauer, but I hope they also recognize the courage of the President of the United States for pushing this issue to a point wherein if we do the work and stop the irrelevant arguments, we have the potential of being able to reform and enact legislation this year that will indeed extend coverage to every single American.

I thank the Chair and yield the floor.

III. THE ROLE OF THE STATES IN REFORM

The Role of States in Health Reform

prepared by
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AS federal health reform lurches forward, states continue to move ahead on reforms to achieve two objectives. First, to control the soaring health care expenditures that are consuming a growing proportion of state budgets. Second, to extend health care coverage to more state residents.

States have long played a key role in the health system. Traditionally, states are responsible for paying for and providing health care services for certain state residents who otherwise would be without coverage. States also play an important role in protecting the public health and safety by providing sanitation, disease monitoring and other public services, as well as establishing licensing and other processes by which to govern provider and marketplace activities.

In recent years, Medicaid, which pays for health services for certain low-income individuals, has become the monster that ate the state budget. State Medicaid spending soared throughout the late 1980s. By 1992, Medicaid spending consumed nearly 18 percent of the average state's budget — contributing to an economic crisis in many states and leaving precious little for education, criminal justice, and other state priorities.[1] Experts cite a number of reasons for the increases in Medicaid spending, including federal mandates that shifted more of the responsibility for covering otherwise uninsured individuals to states, the recession, and ongoing increases in medical care inflation.

The economic crisis faced by many states has left the states with few alternatives. To reduce health spending, states have the option of cutting existing programs and services, increasing taxes, and/or developing plans to reform the state's health care system to cover more residents in a cost effective manner.

This article discusses possible directions for state reform initiatives with and without federal health reform. It then describes recent activities by states to control rising state health care expenditures and extend health care coverage to state residents.

Directions for State Health Reform

In light of the economic crisis facing their states, a growing number of states have concluded they cannot wait for comprehensive national reform. In response, states have elected to move ahead with practical solutions of their own design to the health care problems facing their states. Regardless of the direction federal reform takes, states will continue to play a large role in the health system. If, for example, federal reform stalls, states will likely to continue doing as they are now — developing plans to cover uninsured state residents and contain state health care expenditures.

If federal reform is enacted, states may find themselves:

— operating state health programs within broad federal guidelines — establishing and overseeing health purchasing alliances, implementing costs containment strategies, developing alternative delivery systems, building network and infrastructure capability, and collecting and analyzing data.

— "opting-out" of the federal plan and developing their own program while meeting broad federal guidelines.

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— retaining their current responsibility for services not included under the national plan— long-term care, services to the mentally or developmentally disabled, and health care benefits or cost-sharing subsidies for the low-income population not covered in a basic benefits package.

— informing consumers of their options under the system.

State reform initiatives can be broken into several broad categories. These categories are comprehensive, incremental, managed care reforms, and planning commissions or task forces. The remainder of this article discusses initiatives within these categories.

Comprehensive State Reforms

Comprehensive reforms have, as their primary objective, promoting universal access to health services to state residents. These reforms often combine public and employer-based financing with mechanisms to contain costs and increase the supply of health care providers.

Several states have implemented "play or pay" programs — programs mandating that employers provide coverage to workers or contribute to a public plan on behalf of workers. Hawaii enacted such a program in 1974. The Hawaii program requires employers to provide coverage to all full or part-time workers. Medicaid and state-only funds pick up coverage for residents who would not be covered under the mandate.

The Hawaii program has been successful in extending coverage to nearly all state residents. Yet, the Hawaii initiative operates under somewhat unique circumstances. The most obvious is Hawaii's location and industry mix which keeps employers from moving across state lines to avoid the mandate or a new tax. Hawaii also escaped the Employee Retirement Income Security Act (ERISA) which has stalled more recent state reform efforts.[2] Hawaii also benefited from the luxury of developing the system incrementally over a number of years. Today, the urgency of containing spending cuts short this option for many states.

Massachusetts and Oregon have also passed play or pay legislation. Although aspects of the Massachusetts law have been implemented, the key piece — the play or pay system — has been delayed until at least 1994. Oregon, renowned for its plan to prioritize Medicaid services, passed play or pay legislation in 1988. Like Massachusetts, the Oregon program has not been implemented.

Vermont has taken a different approach to comprehensive reform. Of the 26 states in which Canadian-style health reform legislation was introduced in 1992, Vermont came closest to passing such legislation. Instead, however, Vermont enacted legislation to develop state single-payer and regulated multi-payer health reform plans to be presented to the legislature in 1994. The Vermont law included provisions to establish a commission to develop a universal coverage plan and unified budget for the state's private and public health care spending. Montana recently passed legislation similar to Vermont's, creating a state Health Care Authority to develop and submit proposals for single-payer and regulated multi-payer reform plans to the Montana legislature by October 1994.

In 1992, Minnesota enacted MinnesotaCare to provide health care coverage to low-income uninsured Minnesotans. The legislation called for small group and other insurance reforms, such as the expansion of coverage for low-income children, statewide and regional limits on total growth in health care spending, and policies to address the shortage of primary care providers in rural and other underserved areas of the state.

Florida passed legislation to ensure access to basic health services to all Floridians by December 1994 through a market-based system. Using a "carrot and stick" approach to coverage, the program initially establishes a voluntary program to provide coverage to all residents. If this program proves ineffective, a state-run mandatory program will be implemented. Legislation passed in Florida also calls for creating 11 community health alliances in the state for businesses with up to 50 workers, state employees, and Medicaid recipients.

Washington State has also recently enacted a reform plan based on a competitive model. Under the Washington program, all state residents will be required to have insurance coverage by 1999. Coverage will be provided by approved health plans which agree to provide covered benefits in exchange for a pre-determined premium.

Incremental State Reforms

A large number of states have passed incremental reforms. These reforms, while they do not provide universal coverage, do take steps to

extend coverage to otherwise uninsured state residents.

Many of the state initiatives address the crumbling small group insurance market. These reforms include requiring insurers to provide coverage to any group that applies, placing limits on pre-existing condition exclusions, limiting variations in premium rates for different industries, establishing basic benefit packages, and eliminating waiting periods before individuals with certain conditions are covered.

Other states have enacted various types of insurance pools. These pools aggregate groups to form larger groups that spread the risk of poor health more broadly. Coverage under the pools can range from those who are medically uninsurable to certain small groups or individuals having trouble obtaining coverage.

Still other states have targeted reforms at specific populations, most commonly low-income children. Pennsylvania, for example, recently enacted a program to provide free or low cost preventive, hospital, immunizations and other health services to about 30,000 children living in families with incomes up to 235 percent of the federal poverty level. New York, Connecticut, Massachusetts and Hawaii also have programs subsidizing insurance coverage for low-income children. Florida has initiated a pilot program providing health insurance coverage through public school systems. Vermont began its "Dr. Dynasaur" program to provide state-funded health insurance coverage for young uninsured children and pregnant women not eligible for Medicaid. The program was recently expanded to include children through age 17.[3]

Managed Care Reforms

States have also turned to managed care as an approach to reform. Managed care helps states provide affordable coverage to small businesses and the uninsured. Medicaid managed care programs help states extend Medicaid coverage to more low-income state residents and control state health care expenditures.

California and New York, in which nearly one-quarter of the nation's Medicaid recipients reside, have initiated major Medicaid managed care initiatives. California has enrolled more than 600,000 Medicaid (Medi-Cal) recipients in managed care plans. The state intends to double enrollment in managed care plans by 1995 and have half the state's Medicaid-eligible population enrolled in managed care by 1996. Similarly, New York plans to enroll ten percent of the state's Medicaid-eligible population in managed care plans by 1995, with half enrolled by 1999. Arizona has a longstanding Medicaid managed care system. This system, the Arizona Health Care Cost Containment System (AHCCCS), was established in 1982 and is the only statewide capitated Medicaid system in the nation.

Commissions, Task Forces, Studies

Other states have elected to create commissions or require studies on health reform. States do this for a variety of reasons. For example, some states choose to study options or aspects of reform while consensus around an approach develops, other states create commissions or task forces as a fall-back when other reform initiatives fail. Still other states conduct feasibility studies of different elements of reform, such as implementation, the impact of reform on rural areas of the state or what responsibilities might be left to the state if federal reforms are enacted.

Conclusion

In examining state reform initiatives, several things become clear. States are not waiting for federal action. Instead, they are pushing ahead with their own reforms. While access is important, cost has become the top reform priority in many states. States which are initiating reform now have the opportunity to benefit from the experience of other states. For example, states can look to Hawaii for how to structure a "play or pay" system, to Oregon for how to design a benefit package, or to Minnesota for how to go about the process of health reform. Similarly, the federal government can learn much about national reform from state actions. The federal government may also learn lessons about how to approach health reform with the public by examining the process states have undertaken.

Yet, without certain essential ingredients, state reform will be difficult at best. States need assistance from Washington. For months, Oregon's attempts to obtain necessary federal waivers for their Medicaid prioritization program was chronicled in the media. Without necessary Medicaid, Medicare and ERISA waivers from the federal government, states will find their reform efforts limited, if not thwarted. Federal financial assistance is also an important way Washington can assist states.

There are also certain state-specific elements important to reform. Leadership within the state is important for reform. States with governors and legislators with an active interest, and solid understanding of the issues involved, in health reform are more likely to pursue reform than those who lack such background. Equally important is the state's economic condition. States, such as California, experiencing particularly difficult economic conditions are more likely to pursue certain reforms, such as managed care initiatives, than other types of reform.

States are presented with an exciting opportunity in the health reform debate. This article has attempted to provide an overview of how states are responding to the challenge to develop reform alternatives to meet the needs of their own states. Regardless of what occurs in Washington, states have already taken, and will continue to take, a key role in responding to the crisis facing state health care programs.

REFERENCES

1. National Association of State Budget Officers, "1992 State Expenditure Report," Washington, DC: NASBO, pgs. 75-76.

2. The Employee Retirement Income Security Act (ERISA) limited the ability of state governments to regulate employers offering self-insured health plans. Employers who self insure their health benefits plans are regulated by ERISA, rather than state insurance laws. With the exception of Hawaii, states have been limited by ERISA in their efforts to treat all health insurance plans in their states the same manner. States proposing employer mandates, insurance pools for high-risk or uninsured state residents, and other reform alternatives have found their efforts limited by ERISA provisions. Several bills have been introduced in Congress to allow states meeting certain criteria to apply for a waiver of ERISA provisions.

3. For information on state initiatives targeting children's health services. See Martha P. King, National Conference of State Legislatures, "Healthy Kids! State Initiatives to Improve Children's Health," April 1993.

IV. THE NEED FOR REFORM IN NEBRASKA

The Need For Health Care Reform In Nebraska

prepared by
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DESPITE a relatively healthy population, Nebraska faces critical challenges in reforming its health care system. Many citizens are without health insurance coverage and many businesses and employees are finding that their health insurance premiums are rising at three or four times the level of inflation. Many rural areas lack the necessary resources to meet their needs and there are serious gaps in the health status of some population groups.

The purpose of this article is to discuss the major reasons why health care reform is needed in Nebraska. The first part of the article identifies some of the major health problems in Nebraska. The next section documents the magnitude of the increase in health care costs and the factors that have contributed to the explosion of Medicaid costs. In the third section, the financial and geographic access barriers in Nebraska are addressed. The final section contains a summary and conclusions.

THE HEALTH OF NEBRASKANS

Compared to the nation as a whole, the general health status of both children and adults in Nebraska is well above average. In its 1991 and 1992 studies, the Northwestern National Life Insurance Company ranked Nebraska fifth among all states in health status. A 1993 study by the same company ranked Nebraska tenth in child health.[1] There is also other evidence to support improvements in the health of Nebraskans. During the decade of the 1980s, for example, the average age at death increased by 2.7 years for males and 3.1 years for females. The age-adjusted death rates for heart disease, cancer, and cerebrovascular disease, the three leading causes of death in Nebraska and the nation, were considerably below the national average. Nebraska's infant mortality rate has also consistently been one of the lowest in the nation.

Unfortunately, there are many serious health problems in Nebraska which often result in premature deaths. Many of the premature deaths occur in younger age groups because of risky lifestyle behavior patterns. For example, motor vehicle accidents are the leading cause of death in the 15-to-30-year old age group. Many of these deaths could have been prevented by using seat belts and by reducing or eliminating alcohol consumption before driving. Many deaths in younger age groups also resulted from suicide, homicide, and AIDS. Most premature deaths for lung cancer can be attributed to smoking. During the period 1987 to 1990, breast cancer was the most common new cancer in females. Despite the relative availability of mammography as means of early detection, 71 percent of women in Nebraska aged 50 and over had not had a mammogram.[2] Most cervical cancer deaths could also be prevented if they are diagnosed in the pre-invasive stage. However, a recent survey found that only 18 percent of all adult women in Nebraska and 30 percent of women aged 50 and over had either never had a Pap test or had not had one in the past five years.[3]

There are many other indications that some Nebraskans are not receiving appropriate health care. One area of major concern is the disparity in mortality rates between white and minority Nebraskans. Figure I displays some of the major differences in the age-adjusted mortality rates

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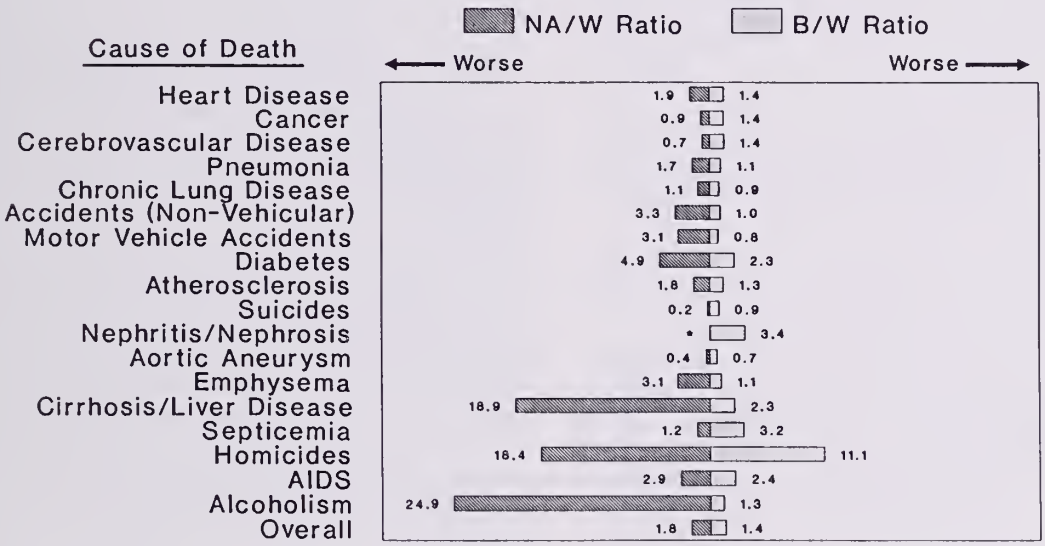
for Native Americans and blacks. According to this table, Native Americans were 16 to 25 times more likely to die from cirrhosis of the liver, homicide and alcoholism. In comparing black and white mortality rates, the greatest differences were for diabetes, homicide, nephritis/nephrosis, cirrhosis of the liver, and AIDS with the black mortality rates being at least twice the white rates.

In addition to minority health status, there are other indicators of poor health. Some of these include the rising levels of substance abuse, child abuse, domestic violence, low levels of immunization, particularly for children under two, teenage pregnancy, and environmental neglect.

This brief synopsis clearly demonstrates that the health of Nebraskans can be improved through changes in lifestyle behavior patterns, early detection of disease, and more timely access to appropriate health care treatment. It is also critical to emphasize that poverty, poor education, and environmental neglect have contributed greatly to poor health, although these factors will not be discussed in more detail here. In the final analysis, however, all health care reform efforts at the state and national levels will ultimately be judged by the amount or degree of improvement in the health of the population.

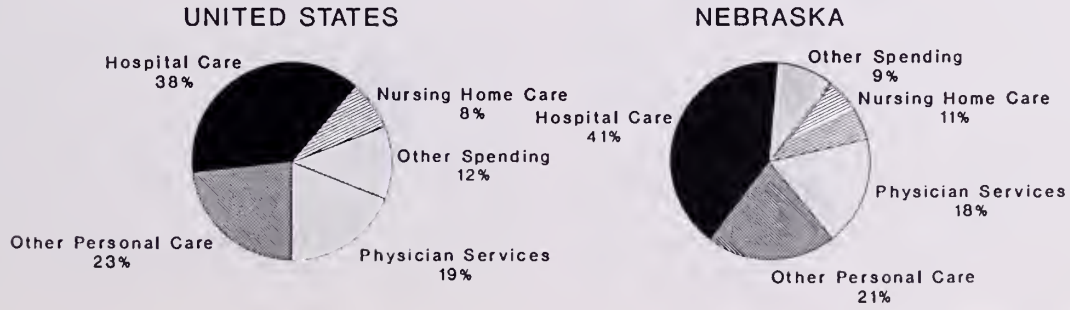
Figure 1--Native American and Black Age-adjusted Mortality Rates (AaMR) in Comparison With White AaMR, 1988-1990



• No deaths among Native Americans reported.

Nebraska Mortality Data, NDOH

Figure 2
Estimated Health Care Expenditures in Nebraska and the United States, 1990



HEALTH CARE EXPENDITURES IN NEBRASKA

One of the major barriers to providing more resources for prevention and improving timely access to medical services is the high cost of health care. Total health care expenditures in Nebraska were $3.9 billion in 1990 and are projected to rise to $5.7 billion in 1993 and to $8.6 billion by the year 2000.[4] Per capita health care expenditures in Nebraska were slightly above the national average in 1990. Per capita expenditures in Nebraska were $2,452 and were projected to increase to $5,576 by the year 2000. The respective figures at the national level are $2,425 and $5,515.[5] In 1990, health care expenditures in Nebraska were 11.3 percent of gross state product compared to 12.3 percent of gross national product in the United States.

Nearly sixty percent of all 1990 health care spending in Nebraska was for hospital care and physician services. As shown in Figure 2, the corresponding percentages were 41 percent and 18 percent. Nursing home care accounted for 11 percent of the total. The percentages for hospital care and nursing home care in Nebraska exceeded the national average by three percent. In contrast, physician services were one percent below the national average.

In Figure 3, the sources of payment for health care expenditures in Nebraska and the United States are compared for 1990. There were significant differences between Nebraska and the United States in the percentage paid by private health insurance and out-of-pocket payments. The respective percentages for private health insurance and out-of-pocket payments in Nebraska were 41 percent and 29 percent, compared to 33 percent and 20 percent in the United States. A major reason for the higher out-of-pocket expenses in Nebraska is the relatively higher expense for nursing home care, which is largely paid for out-of-pocket and by Medicaid. This higher percentage may also indicate that many Nebraskans have large deductibles and co-insurance provisions in their insurance policies. Not surprisingly, Nebraska ranks sixth in the nation in terms of the percent of average family income spent on health care. In 1990, it was estimated to be $4,268 or 12.9 percent.[6]

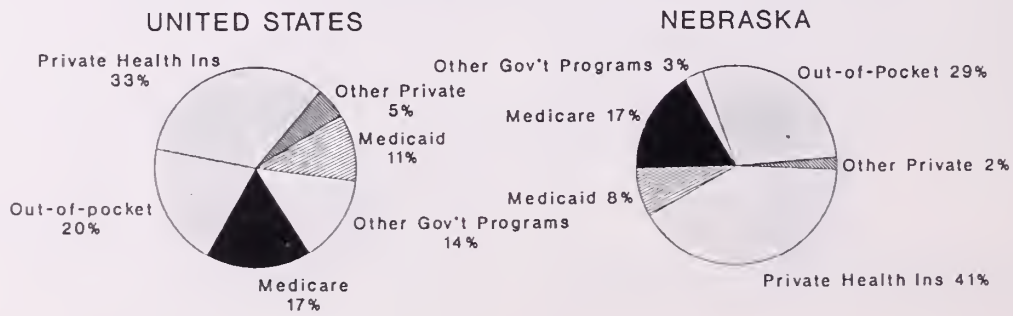
Future Growth of Health Care Expenditures

Without more effective strategies and mechanisms to control health care costs, it is likely that future expenditure increases will reflect past trends. Nationally, health care expenditures rose an average of 10.4 percent in the 1980s and are projected to increase by 9.2 percent in the 1990s. The average rate of increase is expected to be lower in the 1990s because of a projected abatement of price inflation.[7] Although these are national projections, it is very likely that Nebraska expenditure increases will be similar or perhaps slightly below the 9.2 percent increase.

There are several factors that will continue to push health care expenditures higher in the 1990s. These factors include: (1) continued economic inflation, (2) an aging population, (3) advances in medical technology, (4) increasing supply and greater specialization of physicians, (5) higher wages, salaries, and fringe benefits for health care professionals, and (6) continued unrealistic consumer expectations.

Figure 3

Sources of Payment for Health Care Expenditures, Nebraska and U.S., 1990



Consequences for Higher Health Care Costs

Rising health care costs directly result in increasing health insurance premiums, higher taxes to fund government health programs such as Medicare and Medicaid, higher out-of-pocket health-related expenditures, and higher prices of goods and services to pay for the employer's share of increases in health insurance premiums for employees. Another major consequence of higher health care expenditures is that it leads to a growing number of persons without insurance coverage. Increasing expenditures are eventually transformed into higher health insurance premiums, which have been particularly burdensome for the self-employed and small employers. As premiums increase, more of these employers drop or reduce their health insurance coverage, leaving a larger number of people with inadequate health insurance coverage or none at all.

The Explosion of Medicaid Costs

The major source of insurance coverage for low income individuals and families is the Medicaid program. Funding for this program is provided by both the state and federal governments and it covers about 43 percent of those with incomes below the poverty level. Although Medicaid expenditures account for only a small percentage of total health expenditures in Nebraska (i.e., eight percent in 1990), these expenditures represent the fastest growing category in the state's overall budget. In the 1993 legislative session, the expanding cost of this program created a major fiscal crisis.

Total Medicaid expenditures have increased from $259 million in fiscal year 1989 to $445 million in fiscal year 1992.[8] These expenditures are projected to rise to $642 million by fiscal year 1995. The state's share of Medicaid costs has grown from $74 million dollars in fiscal year 1987 to $140 million in fiscal year 1992. They are projected to be $193 million by mid-1993 and $221 million by the end of the 1995 fiscal year.[9]

These expenditure increases have consumed a greater share of the state's general fund budget. In fiscal year 1988, Medicaid expenditures accounted for 6.9 percent of state general fund expenditures. By 1993, they are expected to climb to 11.8 percent and by fiscal year 1995 state Medicaid expenditures are projected to be 13.0 percent of the general fund budget.[10]

Reasons for Expanding of Medicaid Costs

There are many factors that have contributed to the growth of Medicaid costs. The most obvious factor is the increase in the number of Medicaid recipients due mainly to federal eligibility expansions for pregnant women and children. The number of persons on Medicaid grew from 88,000 recipients in 1987 to over 141,000 in 1992. Although most of the growth of Medicaid enrollees can be attributed to pregnant women and children, total expenditures for this group was relatively low (i.e., 18 percent in Nebraska). A recent national study found that these groups accounted for only 11 percent of the growth in Medicaid spending.[11]

A second major factor is the rapid escalation of overall health care costs. Aggregate health care costs have risen at a rate that far exceeds the overall rate of inflation and Medicaid costs are greatly impacted by these increases. A study by the Kaiser Foundation found that medical inflation accounted for about 31 percent of the growth between 1988 and 1991.[12]

A third major factor is the increase in spending for beneficiaries, reflecting a greater demand for services. Between 1987 and 1992, the average dollars spent per recipient in Nebraska increased from $4,216 to $6,190.[13] The Medicaid program has experienced a greater use of services because of a sicker population such as those with AIDS or substance-dependent babies.

There are also many other factors that have contributed to the explosion of Medicaid costs, including higher payments to providers, lowering the federal government's share of Medicaid payments from 64.50 percent in 1992 to 61.32 in 1993, and a growing elderly population, especially in the 85 and older age group. As the population ages, the demand for nursing home care increases. In 1992, the elderly population represented 14 percent of average monthly Medicaid eligibles, but they accounted for 36 percent of total expenditures.[14]

Consequences

The consequences of the growth in state Medicaid expenditures are fairly obvious. First, it forces state policymakers to make serious trade-offs. The more money that is allocated to the Medicaid program, the less money that is available to purchase other services such as education, environmental improvements, or to lower taxes. Second, since Medicaid provides insurance coverage for less than one-half of those persons below the poverty level, it will be

difficult to extend coverage, either through Medicaid or some other program, to those individuals and families below the poverty level that are currently ineligible for Medicaid. Finally, if escalating Medicaid costs cannot be controlled, the state may be forced to make sharp program cutbacks. The net result would be less coverage for those who can least afford it.

Financial Access

Many Nebraskans cannot afford to purchase health care services because of low incomes and the lack of health insurance coverage. Studies conducted by the University of Nebraska Center for Health Services Research have found that the number of Nebraskans without health insurance has grown considerably during the decade of the 1980s. By 1990, it was estimated that about 155,000 Nebraska residents, including 55,000 children, did not have any health insurance coverage.[15] Although this estimate dropped to 140,000 persons in 1991,[16] most of the decline can probably be attributed to the expanded federal Medicaid eligibility requirements.

The uninsured in Nebraska and the nation as whole tend to be children, young people between the ages of 18 and 30, and those with pre-existing medical conditions not covered by insurers. Those of working age are likely to be employed (71 percent) and have incomes of less that $15,000. In 1990, there were only minor differences between rural and urban areas, but the uninsurance rate for African-Americans compared to whites was substantially higher.[17]

It also appears that there are a substantial number of Nebraskans who are underinsured. Applying conservative estimates based on national studies, it is estimated that at least 90,000 residents are underinsured. These would include individuals and families who lack coverage for catastrophic medical expenses or have a very low maximum payout for an episode of disease or for a lifetime coverage limit. Also, many insurance plans covering small groups and individuals have pre-existing illness clauses that deny payment for illnesses present at the time policies are purchased.[18]

Reasons for the Growing Uninsured and Underinsured

There are several reasons why the number of uninsured and underinsured has grown in Nebraska. First, most employment growth during the 1980s was in the service sector and in small businesses, employers who do not routinely offer group health insurance coverage. These industries employ a significant number of part-time workers and generally pay low wages. Although the national unemployment rate dropped by almost one-half during the 1980s, the number of uninsured continued to increase throughout the mid-to-late 1980s and early 1990s.

A second factor is the increasing tendency for employers to require employees to contribute toward their health insurance premiums, including paying the full cost of dependent coverage. Premiums for individual coverage generally are in the range of $1,500 to $2,000 a year; family coverage costs between $3,500 to $4,500 a year. Since real wages have not grown in recent years, many people find the monthly dependent premium a hardship. In Nebraska, and nationwide, it is estimated that more than one-third of the uninsured are children; many of these children have employed parents.

A third reason for the increasing number of uninsured persons is the unrestrained increase in health care costs over the past 15 years. Health care costs have risen at an annual rate of 10 to 12 percent almost every year since the late 1970s. This trend has resulted in substantial increases in health insurance premiums, making it increasingly difficult for many small employers and individuals to purchase coverage. In order to control these spiraling premiums to small businesses, health insurers have initiated changes in insurance practices that make it extremely difficult to cover those with the highest risks. Some of the more common insurance practices that have resulted in more uninsured and underinsured include:

- Imposing limits on the extent of coverage offered by policies, which means that a family may find a particular condition is not covered, or is covered only up to a certain amount;
- Limiting or denying coverage to individuals with pre-existing medical conditions, which means that when a company hires a worker, its insurance plan refuses to pay for treatments related to an existing or previous illness for which the worker, or a dependent of the worker, has been treated in the past;

- Denying coverage to individuals or the employees of businesses engaged in certain occupations likely to incur high medical costs;
- Limiting coverage for preventive health services, such as an annual or semi-annual physical;
- Charging steep premium increases to renew coverage for groups in which one or more individuals previously have filed large claims, or refusing to renew coverage for the group unless individuals with expensive medical conditions are dropped from the group's policy.[19]

The Effect of the Prudent Buyer

The most significant factor contributing to the growth of the uninsured is the "prudent buyer" mentality of some payers. Using a prudent buyer approach, the government, through Medicare and Medicaid, establishes reimbursement rates that do not cover the total medical charges incurred by program recipients. In addition, certain private payers such as HMOs and PPOs negotiate discounted rates with selected providers; sometimes these rates fail to cover the total cost of treatment.

To compensate for these losses, hospitals try to maximize the revenues they receive from private insurers, self-insured employers, and self-pay patients. As a result, the charges to these payers are considerably higher than the actual cost of care delivered. It is estimated that this informal tax, known as the "cost shift", accounts for about one-third of premium increases for private insurers, self-insured employers, and self-pay patients. A recent study concluded that private payers' cost shift burden will rise from about 25 percent (more than costs) to 38 percent (more) between 1989 and 1992. The magnitude of the cost shift is large and growing — rising from 11 percent of hospital costs alone in 1989, to 14 percent in 1992.[20] According to the Nebraska Hospital Association, hospitals in Nebraska were paid only 72.3 percent of the actual costs of caring for Medicaid patients in 1989. This reimbursement percentage was six percent below the national average.[21]

As cost shifting intensifies, the uninsured become more vulnerable. According to Coddington, et al., cost shifting has developed into a spiraling, self-feeding process that functions as follows:

- The federal government, through Medicaid and Medicare, pays less and less of the cost of services received by the poor and the elderly.
- Each year another 700,000 Americans become eligible for Medicare, increasing the total amount of underpaid care.
- A few managed care plans, mostly staff-model HMOs, control their physician costs and either own their own hospital(s) or have sufficient negotiating leverage to minimize exposure to cost shifting.
- The remaining health plans get socked with disproportionately large physician and hospital cost increases. Being virtually defenseless against the increases, these plans attempt to offset losses by raising premiums paid by groups and individuals.
- Small employers, hit with higher premiums, reduce or eliminate health plan coverage rather than pay more. The number of working but still uninsured employees increases sharply, leading to a shift of more costs to the ever smaller base of employers still providing coverage.
- Rates go up again, more employers drop out and the process repeats itself in an ever-expanding circle.[22]

The Impact of Lack of Insurance

There is substantial evidence to indicate that persons without any insurance and those whose insurance does not cover preventive services are likely to delay medical care as long as possible. Because of these delays, the uninsured generally have worse medical outcomes than the insured population as they tend to be more seriously ill than the insured population when they enter the health care system, and they generally require more expensive medical treatment. The uninsured are also less likely to have a regular source of primary health care and more likely to receive care in a hospital emergency room than the insured. A 1990 study of Epstein, et al., found that hospitalized patients of lower socioeconomic status and longer hospital stays utilized more inpatient resources than other patients. The magnitude of the difference ranged between 5 and 25 percent.[23] The Office of Technology Assessment recently evaluated 24 studies and found that Americans without health insurance coverage are three times more likely to receive inadequate health care and suffer adverse health outcomes than those who have insurance.[24]

THE UNIQUE NEEDS OF RURAL NEBRASKA

Most of the problems previously described affect both urban and rural areas. However, rural areas also face several other unique challenges. Any national or state health reform package must address these needs in order for all Nebraskans to have reasonable access to care.

Demographic Trends and Economic Conditions

The population is continuing to decline in most rural areas of Nebraska, decreasing by almost six percent from 1980 to 1990. Eighty-three of the state's 93 counties lost population during this decade, mainly due to an exodus of adults in the 18- to 45-year-old age group. As a result, the population in rural areas is disproportionately elderly, averaging 18 percent of rural county totals compared to 10 percent in Nebraska's metropolitan counties. In fact, 37 counties have an elderly population in excess of 20 percent. Rural Nebraska is economically dependent upon agri-business, and this sector of the economy has been under major stress in the last two decades. The paucity of non-agricultural job opportunities in many rural areas has had a significant and continuing impact on declining populations. The loss of small businesses and service establishments coupled with a decline in real estate values and total population have eroded the tax base to the point where there is little incentive for private investment, particularly in health care.

As a result of population shifts to urban centers and other states, the number of service areas in most rural markets in Nebraska has declined substantially over the past half century. Shrinking populations have intensified competition among rural communities as each tries to expand its service areas to maintain an adequate population base. As service areas grow larger, small communities are left to compete with larger communities and frequently lose services, including health care, to these larger service centers.

Lack of Health Care Professionals

The lack of health care professionals is probably the most formidable barrier to obtaining health care services, particularly primary care services in rural Nebraska. Currently, 18 counties do not have a primary care physician residing within their boundaries. During 1991, there was a net loss (i.e., leaving versus locating) of 16 physicians in communities with populations under 10,000. In 1992, the net loss was only one, but there are still at least 60 small communities trying to recruit physicians and 39 other communities where there is only one physician.[25] Given the fact that most younger physicians are choosing to practice in relatively large group practices (four or more physicians), it is very likely that many communities will find it difficult, if not impossible, to recruit physicians into a small practice.

In some areas of Nebraska, the gap in primary care services has been reduced by physician assistants and nurse practitioners. Unfortunately, the geographic disparities for these health professionals are very similar to those of physicians. Of the 188 physician assistants practicing in Nebraska in 1992, over 60 percent practice in Lincoln or Omaha. In 1980, only 36 percent of all physician assistants practiced in urban areas.

In 1992, only 52 nurse practitioners were active in Nebraska and fewer than ten practiced in underserved areas. Their numbers should increase in the next two years, however, because a new training program was initiated by the University of Nebraska Medical Center last August in Kearney.

A report by the Interagency Health Care Advisory Committee documented shortages of other health professionals in many areas of Nebraska. Nursing schools in the state are now graduating an increasing number of nurses, but few are locating in severely underserved areas. There are also major shortages of physical therapists, radiology technologists, respiratory therapists, social workers, and psychologists.[26]

Hospital Care and In-Home Service

Nebraska has an adequate supply of hospital beds and those beds are accessible (i.e., within a 30-minute travel time) for 90 percent of the population. However, many rural hospitals are facing serious financial difficulties. Between 1986 and 1991, seven rural hospitals closed although most small rural hospitals continue to remain open because of public or private subsidies. The main reasons for these financial problems are the loss of population, government reimbursement programs, health insurance affordability, and a perception that smaller hospitals with less advanced technology provide a lower quality of care than do regional or urban hospitals.

In terms of long-term care services, Nebraska ranks second in the number of nursing home

beds per thousand elderly. These beds are also reasonably distributed across the state so that it appears that the need for nursing home beds has been met. However, many areas lack in-home services such as home health care, adult day care, respite services, and homemaker services. Given the small population base in many areas, some of these services probably cannot be offered without considerable subsidies from the public sector. Nevertheless, Nebraska must find ways of providing more in-home services to those with chronic disabilities and limitations in performing their activities in daily living so that they can continue to live in their own home as long as possible, and to moderate the cost of nursing home care covered by Medicaid.

Summary and Conclusions

This paper has identified some of the major health care problems in Nebraska. Although Nebraska does not face as many serious challenges as some other states, there is clearly a need for reform. For example, the health of our population is generally good, but many serious gaps exist, particularly for minority population groups.

Per capita health care costs in Nebraska are only slightly below the national average, and out-of pocket costs for the average Nebraska family rank among the highest in the nation. In addition, Medicaid costs are exploding and create serious challenges to balancing the state's budget.

Nearly 140,000 Nebraskans lack health insurance coverage and at least 90,000 others are underinsured. Many insurance policies limit or deny coverage to individuals with pre-existing medical conditions, deny coverage to individuals employed in certain occupations, and limit coverage for preventive services. "Cost shifting" continues to become more widespread, which significantly increases the number of small businesses that drop or reduce health insurance coverage for their employees.

Finally, rural areas face some unique challenges related to their ability and capacity to provide services. There is a serious shortage of primary care physicians, mid-level practitioners, and many other allied health professionals. As a result, individuals, including a large elderly population, must travel long distances to obtain care. Many rural hospitals are under severe financial stress and some will close during the next five years. There appears to be an adequate supply of nursing home beds in rural areas, but many communities lack adequate in-home services.

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V. REFORM INITIATIVES

Health Care In Nebraska

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Senator Wesely is the Co-chairman of the Inter-Agency Healthcare Advisory Committee as well as Chairman of the Health and Human Services Committee for the Nebraska Legislature.

TODAY Nebraskans face several serious health care problems, ranging from rising costs, the affordability and availability of health insurance, and the lack of health care resources in some of our rural areas. Although the general health of our people is quite good, there are real shortcomings for large groups of our fellow Nebraskans.

Overwhelmingly Nebraskans recognize the need for health reform in our state. Not only because of the high cost of health care but also because of the increasing problems of access and security for significant numbers of our citizens. These concerns have culminated in the formation by Governor Nelson of two task forces: the Blue Ribbon Coalition and the Inter-Agency Healthcare Advisory Committee (IAHCAC). I was named co-chair of the IAHCAC along with Dr. Mark Horton, the Director of the Department of Health.

The Blue Ribbon Coalition focused much of its attention on the development of a basic benefit package. The IAHCAC centered our efforts on recognizing the specific and unique characteristics of Nebraska and how these would need to be dealt with as comprehensive national reform moves forward.

Accordingly, our committee addressed a wide variety of issues: demographics, aging, physician location and specialty distribution, and sociologic variations in our population.

We recognized that simply changing the health care system in the United States will not necessarily give us a healthy society. While increasing immunizations and having pre-natal care available are examples of important health initiatives, we must also deal with the issues of a deteriorating family structure, widespread violence, and a lack of personal health responsibility by some of our citizenry.

No amount of money will stem the use of medical care without emphasizing both personal health responsibility and the comprehensive availability of preventive services. Such preventive services must be encouraged as we move towards the State's Year 2000 objectives.

We do feel there are some basic principles that are essential to comprehensive health care reform:

. . . universal access for all citizens to a basic benefit package without imposing undue financial or cultural barriers

. . . promotion of a continuity-of-care concept with a reasonable freedom of choice of providers

. . . control costs by administrative efficiency and ending duplication of services

. . . develop and support health promotion and prevention of illness and injury

In a more general sense, we feel we should build on the strengths of the current Nebraska health care system. We need to be innovative and flexible and provide for local planning for significant change in the design of our present system.

The IAHCAC did not propose a single plan for health care reform. At the same time, we recognized that without a comprehensive approach we could not cover the 155,000 uninsured Nebraskans. The challenge for our state and nation is how to reach out to the uninsured and provide health care coverage while streamlining the health care system to control costs.

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There are many factors which are driving up the costs of health care in our state which are not within our control: the aging of our population, general inflation and technological advances in medicine. However, there are others, equally important, that could be in some part contained by a strategic plan. These include:

. . . over reliance upon fee for service medicine and overuse of specialists and their technologies

. . . the need for physicians to protect themselves from malpractice suits by practicing "defensive medicine"

. . . lack of coordination and duplication of services, procedures and facilities

. . . traditional reimbursement methods for hospitals can encourage higher expenditures

. . . consumer expectations can increase health care costs

. . . the administrative overhead of governmental regulation and private insurance paperwork.

These factors have created a complex web that has literally kept many of the underserved outside the medical delivery system.

There are no singular heroes in this debate. Providers, consumers, insurers and governmental agencies all deserve some portion of the responsibility for our health care problems. However, this is not the time to establish blame. These same groups must work together to improve the quality of care to an increasing number of our neediest citizens. We must move quickly to contain costs while developing a long term strategic plan that will work in concert with any national program.

The IAHCAC believes that state should:

1. Establish requirements for a minimum benefit package and rating practices for all health insurance plans.
2. Review and develop practice parameters in concert with providers and distribute them throughout the state.
3. Establish a mechanism to develop uniform rates and charges for health care services which are responsive to the state's and consumer's needs and based upon actuarial data regarding their real cost.
4. Establish regional health planning boards which review and are responsible for the development of new programs or services in their areas.
5. Stress the importance of prevention and risk reduction programs in the work place.
6. Require insurers to develop a common insurance claims form.
7. Develop a central information depository which may be used to compare costs and quality of services within the state and region.
8. UNMC should be encouraged to train a larger number of primary care practitioners and assist them in locating in rural areas.
9. Encourage rural residents to use local health services that may be linked to other integrated networks.

The IAHCAC has also evaluated the needs for managed care, assessment of expensive technology, and the major role that the federal government will play in any type of reform. Nevertheless, the Committee feels that in order to have a plan that is consistent with the needs of the citizens of our state, we should move forward rapidly to identify our specific needs, inadequacies and the potential solutions for this complex issue which affects each of us on a very personal basis.

Your input as physicians is vital to both the structure of health care reform and its ultimate success. Physician input into controlling cost is absolutely essential as we note that physicians receive about 18 cents of each health care dollar but are possibly responsible for how another 60 cents of that same dollar are spent. Without substantive comments from individual providers and organized medicine, the process will be lengthened and perhaps off target. We welcome your comments and your constructive criticism.

V. REFORM INITIATIVES

Health Care Problems And Nebraska Solutions

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I thank the Nebraska Medical Association for the opportunity to discuss with the readers the work of the Governor's Blue Ribbon Coalition to study health care in Nebraska, our initial findings and future activities.

The Coalition is made up of a diverse group of 33 men and women from across the state. We have representatives from the AARP, the medical profession, businesses large and small, hospitals, medical schools, administrators of small, rural hospitals, consumer advocates, labor, insurers, agriculture, nursing profession, mental health system and a representative from Senator Kerrey's office.

The charge given by Governor Nelson to the Coalition in January, 1992 was to come forward with recommendations to improve the health care system in Nebraska, both public and private to provide access for all of our citizens to quality, affordable health care.

The Blue Ribbon Coalition has been meeting since January, 1992, and have, through its committees and subcommittees, had a great number of meetings to discuss problems in the health care system in order to formulate recommendations to the Governor.

We first developed the principles that would guide our deliberations and recommendations. They are a part of this article as they form the basis of what we are about and what we have and will recommend to the Governor.

STATEMENT OF PRINCIPLES

PREAMBLE: All Nebraskans have the right to quality health care at a cost they or society can afford. Government, health care providers, insurers, businesses and consumers must work together to accomplish this goal. A partnership between government and the private sector may ultimately provide the most favorable solution to developing quality health care services at a cost that is affordable to all of our citizens.

1. **ACCESS.** All Nebraskans have the right to geographical, cultural and financial access to basic health care services. Defining basic health care services should be accomplished by society with the assistance of experts in the field.

2. **QUALITY.** Mechanisms should be developed to assure that all Nebraskans receive quality health care services.

3. **COST CONTAINMENT.** The financial, political and social incentives driving our health care system must be adjusted to assure that they promote cost-effective behavior. It is important to develop innovative approaches and incentives to encourage affordable and efficient health care services.

4. **RESPONSIBILITY**. Promoting access to basic health is a shared responsibility of individuals, society, providers, payers and government.

a. **INDIVIDUAL**. Individuals must be responsible for leading healthy lifestyles. To protect individual dignity, everyone who can, should pay for some of the cost of his or her own care.

b. **SOCIETY**. Society should promote improved consumer education so that Nebraskans can become more proactively involved in both prevention and wellness focused lifestyles, as well as become better informed health care purchasers. Society should develop mechanisms to understand the ethical, economical and rationing issues necessary to determine how medical services and procedures will be allocated.

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c. **PROVIDERS.** Professional and institutional providers, both individually and collectively, must deliver high quality and humane care to all Nebraskans. They should develop practice guidelines and outcome data that encourage the appropriate use of health care resources. Providers must assume a key role in the development of a comprehensive delivery system which supports access, quality and cost containment. Providers must develop practice guidelines which encourage necessary and preventive services and eliminate unnecessary services. Charges for services rendered should be fair and reasonable.

d. **PAYERS**. Payers, working with government, have responsibility for designing systems that provide coverage for a basic package of health care services for all Nebraskans, regardless of condition of health, state of employment or ability to pay. They should create mechanisms to pay for care with a minimum of administrative cost, uncertainty, confusion, bureaucracy and paperwork.

e. **GOVERNMENT.** Working with providers, consumers and payers, government has the responsibility for developing incentives and creating an affordable system of universal access to basic health care for all Nebraskans. Government also has special responsibilities to provide public health services, educate the public on health matters, address the social conditions that cause illness and drive up health care costs such as poverty, malnutrition, inadequate housing and violence.

f. **EDUCATIONAL INSTITUTIONS.** Nebraska institutions of higher education, public and independent, that conduct health professions education programs should strive to meet the needs of our citizens for health care professions. Those institutions that engage in biomedical and health care research are also responsible for contributing to improvements in quality and delivery of health care in Nebraska.

5. **FLEXIBILITY/FREEDOM OF CHOICE**. Individuals and families should have a basic health plan that is portable and affordable and the freedom to choose additional health insurance based upon their financial capability.

6. **INNOVATIVE**. Delivery and financing arrangements must promote development and dissemination of more effective and efficient methods for treatment and prevention. Methods to deliver health care services must be responsive to Nebraska's diversity. There must be local involvement in the planning, development and design of the health care delivery system in cooperation with federal and state efforts. This process must include representatives from all major sectors of the community, including both public and private entities.

7. **FINANCING.** Health care financing must be organized to prevent cost shifting. Health care services should be financed through a public/private pluralistic system. The system should provide incentives to consumers to use appropriate health care services and to providers to assure value for the price of services rendered.

The Coalition's work has led to the conclusion that there is no *one solution* to our health care problems. There is a series of *solutions* by which we can change and improve the delivery and financing of health care.

What does our group believe to be the most critical concerns (priorities) for the development of public policy relating to health care reform?

FIRST. The most critical concern is to determine that quality health care is a right for all citizens, and then define what that truly means. Does it mean a right to a heart transplant for an 85 year old person whose chance for life is minimal? Does it mean hair transplant for the bald person? Does it mean invitro fertilization for those who seek conception? The first question is - What is quality health care? If it is a right — a right to what? This is a most difficult issue. Our Coalition is in the process of developing what we consider to be a quality health care core benefit package, one which will promote excellent health care coverage for the vast majority of our citizens, yet help contain costs and be affordable from society's standpoint.

SECOND. How do we *fairly* pay for this right, particularly for those of our citizens who cannot afford to pay for their own health care needs?

THIRD. How do we assure society and the individuals who make up that society that the system is fair to all and that all segments of the health care system — insurers, providers, employers, consumers, hospitals and doctors — will be called to do their fair share?

FOURTH. It is essential that we develop an information support system which will assist in monitoring the status of health care in this country and provide a methodology to measure our progress. This includes development of practice parameters and outcome results as to the effectiveness of certain procedures, surgeries and treatments.

Those are the issues the Coalition considers to be some of the most important items for debate and resolution. We have just begun to explore the surface of this multi-faceted project. The complexity of this problem is one of its dangers in that the states, in despair, might throw up their hands and suggest that the "experts" in Washington solve the problems. This would be a disaster for our citizens.

I say this because health care — *quality, affordable health care* — must be planned and directed by the communities served and by the individual states. The federal government has been a significant factor in driving up costs with its inflexible, burdensome administration of the health care programs and its continual shifting of costs away from itself to the states and other payers. We must **all** work to correct that situation.

The Coalition developed an outline of coverages which would provide a standard by which all health insurance programs could be judged. We are attempting to cost this program, which we call **Nebraskare**. This is a difficult task because our program includes a comprehensive benefit plan and is designed to include preventive, health, Medicaid, comprehensive health insurance plan (CHIP) participants and those *150,000 uninsured Nebraskans.*

PROPOSED NEBRASKARE BENEFITS

Lifetime Maximum — $1,000,000 Per Insured

IN HOSPITAL BENEFITS — USUAL AND CUSTOMARY
- Semiprivate Room
- Skilled Nursing
- Home Health Care
- Hospital Outpatient Care
- Intensive Care
- Surgery and Anesthesia
- Hospice Care
- Prescription Drugs (According to State Formulary)

OUTPATIENT BENEFITS
- Ambulance
- Doctor Office Visit
- Laboratory
- X-Ray, Radiation, Chemotherapy
- Prescription Drugs (Formulary Only)

DEDUCTIBLE AND CO-PAYMENTS
- Deductible — $500/Year-3 Deductible Maximum/Family
- Co-Payment — 80%/20%
- Out-Of-Pocket Maximum — $2,500/Year Per Family; $1000/Year Per Individual

Deductibles, co-payment and out-of-pocket expenses would be reduced by income tier.

- No Provider Waiver of Deductible and Co-Payment
- No Provider Balance Billing

MENTAL, NERVOUS, ALCOHOL AND DRUG TREATMENTS
- Subject to Plan Deductibles and Co-Payments
- Coverage According to Managed Care Provisions
- $50,000 Lifetime Maximum
- $25,000 Annual Maximum

OTHER COVERAGE PROVISIONS
- Maternity Benefits
- Preventive Benefits Tied to Income Tiers
- Prescription Drugs According to Formulary

COST CONTAINMENT AND QUALITY CARE
- All Benefits Restricted to Provision by Approved Providers and Practitioners Only
- Hospital Pre-Certification and Case Management
- Centers of Excellence for Specialized Care

GENERAL EXCLUSIONS
- Pre-Existing Condition for 1 Year if a First Time Entrant
- Experimental Procedure or Drugs Defined by an Oversight Board
- Dispute Resolution by Arbitration Versus Litigation
- Elective Services and Procedures Except as Specifically Defined by an Oversight Board
- Waiver of State-Mandated Benefits.

I am convinced intelligent men and women can change the health care system and devise methods and procedures to control cost. But no health care reforms without cost containment will succeed. It is the cost which drives the debate for reform. We must change the way we provide, utilize and finance health care in the State of Nebraska and in this nation. We can do it, but it is going to take sacrifices on behalf of the doctors, hospitals, lawyers, insurance companies, labor unions, employers, employees, the poor, the middle class and the affluent.

In short, all segments of our society must change the way we provide health care and the way we finance it. Let's retain the good from the existing system, discard the weak links and move forward. We must allow experimentation within the system to find the best. To accomplish this, our Coalition has recommended that the State of Nebraska give consideration to seeking designation from the Clinton Administration as a demonstration project state to experiment with changes in our health care system, its delivery, financing and quality.

The current debate is absolutely essential if we are to properly reform our system, and it needs reforming. The members of the Governor's Blue Ribbon Coalition have been involved in studying various aspects of health care reform since January, 1992. We have just begun our review of the enormous number of issues which need to be debated and decisions made. It is truly an exciting, challenging and necessary activity.

We thank the physicians who are active on the Coalition for their superb contributions to our deliberations. Also, we thank the Nebraska Medical Association for providing the Blue Ribbon Coalition with valuable information and input. We can and we will make significant changes in the system. Much is being accomplished in this state right now. Hopefully, Nebraska's effort will help shape the national debate and the ultimate product which comes out of Washington.

V. REFORM INITIATIVES

Inter-Agency Committee For Health Care Reform

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ALTHOUGH the Inter-Agency Committee did not develop their own plan, it did look at options such as networking and integration of services, managed care as cost containment, and regulatory approaches to controlling costs. This committee also performed the difficult task of assessing health care delivery in Nebraska, the aging of our population, and the problems of rural health care. The committee presented several recommendations which could be amalgamated into a composite plan that would both be consistent with the Blue Ribbon plan as well as much of what we see in the Clinton proposal.

It seems clear that in its present form, President Clinton's Health Securities Act would not allow a significant number of state initiatives or innovation. With the exception of adopting a single payer model, little other opportunity seems available for individual states. Certainly this will be a well debated issue since federal mandates may not be accompained by federal fiscal support.

A Nebraska initiated plan will continue to be developed, with the intent that it will be within compliance of the ultimate health care legislation presented to Congress.

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VI. THE ROLE OF THE ACADEMIC HEALTH CENTERS

The Impact of Health System Reform on Academic Health Centers

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THE process of health system reform has begun with formation of new partnerships among physician groups and hospitals and insurers. It is increasingly clear that health system reform will be evolutionary rather than revolutionary, with formation of integrated comprehensive networks in urban areas, with increased dominance of managed care, and with continued state and federal efforts to curb the rate of increase in spending for Medicare and Medicaid. The fulcrum of public policy debate seems to have shifted toward cost containment, with somewhat less emphasis on universal access. One constant characteristic of discussions of health system reform at both the federal and state level has been inattention to the impact of reform on academic health centers.

The more than 100 academic health centers in the United States are the primary site of education for physicians. They bear much of the burden of charity care and they are the major "economic engines" of innovation in health care in the world. The cost of clinical education of physicians in these academic health centers is financed predominantly by clinical revenues generated on site. A recent analysis by the Association of American Medical Schools indicates that faculty practice plan revenues account for about 40% of the general operating revenues of United States medical schools; using comparable analysis, faculty practice generates about 38% of the operating budget at UNMC College of Medicine. At the medical center level, clinical revenues account for about 54% of operating revenues. Clinical revenues currently subsidize both clinical education and clinical research. Both will be threatened under managed care and cost controls unless a new mechanism for financing education and research is developed.

With managed care, many communities will experience additional reduction in hospital days. Referrals to specialists in the private sector and in medical schools will decrease. Individuals in managed care plans will have limited, if any, latitude to consult specialists without referral from a primary care "gatekeeper". Managed care will increase demand for physician productivity. In particular, primary care physicians will be pressed to see more patients as the number of people in "gatekeeper" health care plans increases. Simultaneously, the demand for more primary care physicians will place greater teaching demand on faculty in family practice, internal medicine and pediatrics. Similarly, recent curriculum innovation at UNMC that places more emphasis on primary care experience and on small group, problem-based learning may be jeopardized by increased demands on clinical faculty and shrinking budgets.

There are many indicators of government intent to control graduate medical education before health system reform occurs. Some federal officials talk about implementing measures that would constrain specialty choice as early as 1995. Debate has centered on changing the ratio of specialists to generalists, with growing agreement that there are too many specialists and too few generalists. As yet, there is no agreement on a fact-based model for specialty mix that would better serve the goal of universal access to basic health care. Recently, workforce estimates by some federal officials, including Assistant Secretary of Health Phillip Lee, have shifted from emphasis on need for more primary care physicians to assertions of total current physician surplus of 50,000. One might ask (I did, without satisfactory answer): If there are

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too many physicians at present, why are they working such long hours and why are so many people complaining of long waits for appointments?

Comments by federal officials at recent professional society meetings indicate that they seek to limit enrollment in medical schools and may attempt to mandate increased enrollment in some other health professions programs. Several study groups, including COGME (congressionally appointed Council on Graduate Medical Education) and the Clinton task force advocate a national commission that would limit the number of graduate medical education positions to the total number of U.S. medical school graduates plus 10%. The commission would also determine the number, specialty mix and geographic distribution of residency positions. These decisions would be made for periods of 5 years and would be based on some estimates of workforce needs and some assessment of program quality. Currently, a high percentage of residency positions are located in metropolitan hospitals of populous coastal states. Residency programs in the midwest could be disproportionately affected by federal regulation, adding an additional barrier to physician recruitment in the heartland.

While there is consensus about the need for more physicians who can provide primary care, federal regulation of graduate medical education as the means to that end poses a number of troubling questions for medical schools. What impact will the restriction of residency selection have on the medical school applicant pool? Will the most qualified students seek other careers where they have freedom of choice? Will student collaboration be replaced by cut-throat competition to get the best grades in order to secure a coveted residency position in a procedural specialty? Since student choices are not likely to change abruptly despite federal mandate, how will schools cope with students' anger at having less choice than their predecessors? Will women and people of color, who only recently have had equal access to some of the most highly compensated specialties, find their choices again restricted?

The creation of a healthy system that would ensure all citizens access to basic health care at affordable cost is highly desirable. If reform is to be achieved without sacrificing the quality of care enjoyed in the United States, a stable mechanism for continued support of medical education and biomedical research must be implemented from the outset. A recent analysis by the American Medical Association's Working Group on Medical Education and Health System Reform concluded: "Government officials and public policymakers involved in the debate on health system reform must recognize the reality that clinical education is integrated with the delivery of health care and must address this issue in a responsible and effective manner when shaping health care reform legislation." This is a critical message that has not yet been heard.

VI. THE ROLE OF THE ACADEMIC HEALTH CENTERS

Medical Education: Leadership and Adaptation In A Changing World

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THIS issue of the Nebraska Medical Journal is dedicated to addressing current discussion and debate on reforming the U.S. health care system. Reform will have profound but probably not immediate effects on medical education.

Medical knowledge and practice undergo constant change. Progress results in changes in the ways medicine is viewed and valued by our society. Medical progress and the high value placed on medical care are at the very root of contemporary movements to reform the system by which health care is delivered in the United States. The quality of U.S. medical care is very good; current reform initiatives are consistently addressed to the system of health care delivery rather than to the nature and substance of disease prevention and medical care.

The scientific and technical progress leading to increased demand for health care, its increasing costs, and efforts to control those costs, began two-and-one-half millennia ago when Hippocrates introduced a paradigmatic change into western medicine. The Aesculapian model of medicine was based on the belief that diseases were of supernatural origin and treatment depended on the intervention of deities. Hippocrates and his followers based their medical practices on careful observation of individual patients and their responses to specific preventive and therapeutic interventions. Thus began the era of western medicine based on empiric observation and experimentation.[1]

The scientific approach to health and illness has produced knowledge and technology that greatly enhance our ability to prevent and treat diseases effectively. More effective medicine is more useful medicine. Greater utility increases demand. A greater number of more effective medical services provided to growing numbers of people has resulted in continuously escalating costs.

Society invented insurance to alleviate the burden on individuals by spreading the cost over a larger population. Health insurance, both public and private, has become widespread in the developed world during the past century.

Increased effectiveness and high costs of health care have given rise to efforts to change the system of health care delivery to achieve cost control and universal access. Cost increases and efforts to control them have strikingly accelerated in the second half, and now the last decade, of the twentieth century.

As scientific medicine has evolved so too has medical education changed to meet the challenges of assuring effective, well educated practitioners prepared to lead in the development of new knowledge and technology, and their application. United States medical education has led and adapted continuously to changes in the substance and mode of medical practice. It must and will continue to change, particularly as societal priorities are reformed.

Contemporary initiatives to change the American health care system are addressed largely to cost control, assurance of access for all members of the society, and maintenance and improvement of the quality of care. Modern United States efforts to control health care costs began in the 1960's and 1970's in response to increased access provided by the introduction of Medicare and Medicaid and the growth of

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employer-provided health insurance that accelerated strikingly during and after World War II. Early efforts included modest expansion of health maintenance organizations (HMOs) in the late 1960s and 1970s. More vigorous and widespread efforts to control costs began approximately a decade ago with the introduction in 1983 of the Tax Equity and Finance Reform Act (TEFRA). TEFRA introduced prospective payment for Medicare reimbursement of hospitals on the basis of Diagnosis Related Groups (DRGs). Nearly simultaneously the private insurance industry and employers accelerated the development of managed care. HMOs were expanded in number and size, preferred provider organizations (PPOs) and expanded utilization review were introduced.

Other efforts to control rapidly increasing costs that have been already introduced or proposed are global budgeting, price controls, including the Resource Based Relative Value Scale (RBRVS), capital expenditure controls, more stringent technology assessment to determine what is effective and will be paid for, administrative simplification, and tort reform.

Reform initiatives to assure universal access are likely to include defined benefits for the nation and will probably include insurance reform including some form(s) of community rating, prohibitions of exclusions and waiting periods for pre-existing conditions, and claims simplification. Enhanced access will also require more primary care, less specialty care, and better geographic distribution of the providers of preventive and primary services.

Reform initiatives to improve quality emphasize prevention and primary care, the development of practice guidelines, and more rigorous outcomes evaluation.

Each of these three goals — cost control, assured access, quality assurance — will have significant effects on the education of medical students and other health professionals.

Those responsible for health care system reform and for changing medical education to adapt to system changes must understand several important principles in the relationships of patient care and professional education.

- Medical education is an integral part of the health care system. Students are educated in health care settings and faculties provide health care for patients in the course of medical student education.
- Medical education is essential to the future of health care. A continuous stream of physicians and other professionals to provide services in the future requires that education be supported and continue to be an integral part of health care.
- Medical education is subsidiary to and serves professional practice. The existence of educational institutions is predicated on their ability to graduate professionals who will serve the needs of the American public. Health professions education must graduate physicians prepared to practice in the system of the future.
- Medical education is costly; students pay only a fraction of the cost of their education. Much, perhaps most, of the cost of medical student, resident, and fellowship education is borne by those who pay for patient care. Hospitals and faculty practice plans provide important subsidies for students and residents. Medical education depends on payments for patient care.

The forces that I believe are affecting and will most strongly affect medical education in the near future are:

- *Cost control* measures, including managed care, prospective payment, imposed reimbursement schedules for physician services, and competitive pricing of health care providers.
- *Incentives* for students to enter primary care specialties and to provide care to underserved populations.
- *Unbundling of education costs* from patient care costs.

Cost Control

Managed care, prospective payment, RBRVS, and competitive pricing have already decreased hospital admissions and caused shorter hospital stays. This has resulted in major shifts of patients from inpatient to outpatient sites and a concomitant change to greater average intensity of care provided for hospital inpatients. Most diagnostic activities occur before admission and most continuing care occurs after discharge. Thus, it has become difficult for students to develop a comprehensive picture of patients' problems and to participate fully in their diagnosis, treatment, and continued care. Furthermore, many problems for which patients were previously hospitalized are now cared for entirely in outpatient settings. Most

medical schools have responded by introducing more required and elective outpatient experiences. Educational sites are moving to reflect changes in practice modes.

Private insurers' and employers' efforts to decrease the cost of care for their subscribers and employees have resulted in their seeking the lowest possible prices for quality health care. In the pursuit of lower prices they have induced movement of patients away from teaching institutions to community hospitals and physician practices that do not bear the costs of education and clinical research. This decreases financial support of medical education and diminishes the numbers of patients available for the teaching of students and residents.

Managed care with its emphasis on primary care physicians controlling specialty services has increased the demand for primary care physicians. This and the general recognition that there has been a shift toward a disproportion between primary care and specialty physicians has led the Association of American Medical Colleges to establish a goal of 50% of United States medical graduates entering primary care specialties.[2] In response to these same forces, many medical schools have introduced mandatory primary care experiences for their students.

Incentives

Incentives to induce medical graduates to enter primary care specialties and care for underserved populations have been designed and are being introduced. Medicare currently reimburses teaching hospitals more for primary care residents and less for specialty residents. Health care reformers promise significantly greater controls on specialty training.[3] In its 1992 re-authorization of the Health Professions Student Loan program (HPSL), Congress changed the loans for medical students to Primary Care Loans (PCL). The explicit congressional intent is to provide low cost, government guaranteed loans *only* for those who promise to enter primary care training and practice. There are severe penalties for those who do not keep their promises and for the schools from which they graduate. These efforts are intended and probably will have the effect of providing fewer opportunities for medical school graduates to choose specialties, thus constraining many to choose primary care.

These forces are likely to result in different characteristics of those who apply to and are admitted to medical schools. Admissions committees are, in response to the AAMC initiative and society's demand, adjusting admissions criteria to select students with profiles indicating those more likely to choose primary care careers. These include women, older applicants, those with undergraduate humanities majors, and those from small town and rural origins.[4]

This might be expected to be of advantage to Nebraska but, unfortunately, the increase in Nebraska residents applying to medical schools has been much smaller than those of other states; only a 9% increase in Nebraska residents compared to a national increase of 31% from 1987 to 1992.[4]

Medical schools are responding in other ways to increase the number of primary care career choices. Curricula are being adjusted to stress primary care experiences and to modify educational approaches to specialties so that primary care physicians will make optimal uses of specialty referral services and ancillary resources.

If the medical education establishment is not adequately responsive to societal demand for primary care physicians, there are likely to be legislative mandates of state schools to produce more primary care physicians or lose support. Texas, Arkansas, and other legislatures have already introduced bills linking medical school tax support to the graduation of primary care and rural physicians.

There is also a strong possibility (some say probability) that primary care may become wholly or in part the province of alternative professionals such as nurse family practitioners, midwives, or physicians assistants. If this occurs, there may be reduced demand for primary care physicians and in consequence necessary reductions in medical school classes.

Unbundling of Educational Costs

Separating the costs of education from health care costs will also modify medical education in important ways.

There are several proposals to require all payers for health care to contribute to a pool to pay the costs of education. In this manner the costs of education will be spread over the entire system so that all beneficiaries of health professions education will pay their share. This will allow teaching institutions to become more price competitive in a market-based system and

may reverse payer-induced shifts away from teaching institutions.

Educational institutions will become more accountable for educational outcomes. In the past education costs have been largely hidden (and protected). Greater accountability will stimulate searches for more cost effective ways of learning and teaching, providing incentives for such new modalities as medical informatics, self instruction modules, and other modern technology. It may also induce the formation of consortia to avoid duplication of educational programs and resources and more cost-effective education. We in Nebraska have a good start on this process in the Creighton-Nebraska Universities Health Foundation and the several combined education and service programs of our two medical centers.

It is also possible that there may be retreat from some effective but high-cost teaching methods. Programmed patients, small group teaching, and some components of problem based learning may be at risk unless they can be shown to be cost effective.

Summary

Health care reform has remarkably accelerated in recent years and is now being driven by economic considerations more than by any others. There have been great changes in medical effectiveness, practice and, in consequence, medical education. These trends will continue and accelerate even more if comprehensive health care reform is achieved. Health care is highly valued by our society and medical education is an integral and essential part of health care. The challenge for health professions educators is to lead constructive change and to adapt to changes imposed by systemic reform to assure that the quality of our graduates enables them to best serve society.

Note: This paper is the adaptation of an oral presentation made to the Association of American Medical Colleges Group on Student Affairs and Organization of Student Representatives in Rochester, Minnesota, May 1, 1993.

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Second Note: This paper refers to efforts to change the mix of primary care and specialty physicians and cities a goal of 50% graduates entering primary care.[2] A recent analysis by Richard A. Cooper of the Medical College of Wisconsin has called into question the "50% solution" adopted by the Association of American Medical Colleges and other organizations dedicated to health care reform. Cooper concludes that if 35% of medical graduates enter primary care, a steady state of 80-85 primary care physicians per 100,000 population will be achieved and maintained. This number is slightly in excess of that estimated to be needed in managed care systems.

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VII. THE POSITION OF THE PROVIDERS

The Position Of The Providers - Physicians

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The American Medical Association (AMA)

THE American Medical Association was one of the first nationally-recognized organizations to bring the problems in the delivery of health care in the United States to the attention of the American public. On 15 May 1991, the Journal of the American Medical Association (JAMA) devoted its entire issue[1] to the issue of health care reform. This "official" acknowledgment by the AMA of the increasing difficulties in the quality, cost, and access to medical care being experienced by a large segment of the American population was one of the milestones that served to launch the national debate on health care reform. This debate continues to intensify as more specific remedies for the resolution of these problems are being proposed, reviewed, and rejected by the current administration.

The AMA has remained in the forefront as the debate on these issues continues. As the representative of the cross-section of American medicine, the AMA developed very early on its proposal for health care reform, entitled "Health Access America".[2] This proposal consists of sixteen broad "points" for health systems reform, as follows:

1. Increase access by enacting major Medicaid reform.
2. Increase access by requiring employer provision of health insurance ("pay or else").
3. Increase access by creating state-level risk pools in all states.
4. Maintain access and reduce costs for the elderly by enacting Medicare reform.
5. Increase access and reduce costs for the elderly by enacting necessary legislation to finance expanded long-term care coverage.
6. Reduce health care costs through professional liability reform.
7. Maintain quality and reduce costs through development of professional practice parameters.
8. Reduce health care costs through altering the tax treatment of employee health care benefits.
9. Reduce costs by encouraging cost-conscious decisions by patients.
10. Reduce costs by seeking innovation in insurance underwriting.
11. Maintain quality through expanded federal support for medical education, research, and the National Institutes of Health (NIH).
12. Maintain quality and reduce costs through increased health promotion and disease prevention.
13. Reduce costs and increase access by amending ERISA or the federal tax code to equalize treatment of self-insured and insurance plans.
14. Reduce costs and increase access by repealing or overriding state-mandated benefit laws.
15. Reduce costs by reducing administrative costs and paperwork.
16. Maintain quality and access through encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care.

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Few people could take exception to the sixteen general points noted above, but, as is usual, "the devil is in the details". Since the AMA is comprised of physicians in all specialties and in all states of the union, it should come as no surprise that there is no real unanimity of opinion among AMA members as to the details and the implementation of all these points. In fact, some specialty societies, even though having representation within the AMA, have taken positions quite divergent from several of the AMA positions.

For example, the American College of Physicians (ACP), a society representing internists, has taken the position that the AMA's Health Access America is "soft" on cost control. The ACP in its "Universal Insurance for American Health Care" paper[3] has taken a position advocating global budgets and expenditure targets as appropriate means of attaining such cost control.

Similarly, the American Academy of Family Physicians (AAFP), the specialty society for family physicians, in its "Rx for Health: the Family Physicians' Access Plan"[4] advocates the gatekeeper approach to controlling access and cost, thus promoting the position of primary care physicians to a much greater extent than the AMA plan.

This divergence of opinion among specialists about the proper ingredients of health care reform is not particularly surprising nor undesirable. Physicians in different specialties, different practice situations, and different geographic areas are just as likely to hold divergent opinions about health care reform as any other segment of the population.

The important point is that, no matter how they may differ on the details of the implementation of health care reform, it can be categorically stated that all physicians are aware of the rapid deterioration of health care delivery in this country, and are willing to devote the full measure of their expertise toward the development of a fair resolution of the problem.

The Nebraska Medical Association (NMA)

The NMA believes that any national initiatives for health care reform will contain a great deal of discretion for states to implement reforms which best suit their own populations and circumstances. In early 1991, Dr. Paul Collicott (then President of the NMA) appointed on the Committee on Health Planning. The charge to this committee was to evaluate the different proposals for health care reform, determine which proposals would be best suited for the citizens of Nebraska, and to develop positions for the NMA to present to state and local forums on health care reform. This committee, co-chaired from the beginning by Drs. Herb Reese and Allen Dvorak, has become the most productive and active committee in the NMA structure.

At is Annual Session in April of 1992, the NMA House of Delegates officially adopted the "White Paper" presented by the Committee on Health Planning, entitled: "Nebraska Health Care Reform".[5] At its 1993 Annual Session the same body adopted two additions to the "White Paper", one on Managed Competion and one on Practice Parameters/Guidelines.[6]

The NMA believes that the reasons behind health system failure are manifold, and include:

1. Demographic changes — the aging of the population, especially in rural states.
2. The development of technology that has advanced beyond the ability of society to pay (i.e., it is impossible to guarantee all available services to all citizens).
3. Simple inflation, magnified by the increased demand brought about by technological advances.
4. Excessive administrative, bureaucratic, and regulatory costs brought about by well-meaning government mandates at all levels.
5. The necessity for "defensive" medicine, brought about by the American public's zeal to make physicians responsible for imperfect medical outcomes.
6. Increased demand for services brought about third party payment for health services (i.e., the divorcing of patient care from the payment of such care), virtually eliminating market forces from constraining the cost of health care.
7. Illogical and incomplete reimbursement by government payors, leading to massive "cost shifting".
8. Illogical reimbursement among physician specialties, resulting in a relative surfeit of procedural specialtists, and an absolute paucity of the number of primary care physicians.

The NMA advocates the following "Fundamental Concepts" for state and national health care reform:

1. All persons in Nebraska should have access to "basic health care" services.
2. The definition of "basic health care" should be made by the citizens of the state, with input by physicians, legislators, and others involved in health care delivery and reimbursement (the "Oregon" model).[7,8]
3. "Rationing" of health care will therefore occur, but such rationing should be made on the basis of what services are guaranteed for all, rather than on who can receive all services, as is currently the case.
4. Private payors (employers, individuals) should assume financial responsibility for health care if they are above the federally-designated poverty line, while government (state, federal) should guarantee payment for those below the poverty line, including a sliding scale based upon the individual's ability to pay.
5. Nebraska should embark on health care reform planning independent of federal health care reform.
6. In implementing a "Basic Health Care" plan, there must also be enacted a liability shield for providers.
7. "First dollar coverage" for health care services should be virtually eliminated; i.e., everyone should be held responsible to some degree for payment for his/her health care services.
8. Any new plan for health care delivery should incorporate the strengths of the current system, while striving to eliminate its weaknesses.
9. All state laws mandating specific benefits for health insurance should be repealed in favor of the "Basic Health Care" package.
10. Every effort should be made to increase the relative and absolute numbers of primary care physicians.

The NMA plan diverges from the AMA's "Health Access America" by not endorsing the strategy of mandating employers to provide insurance for all employees and families. The NMA believes that such a policy is impractical in a state such as Nebraska, which relies heavily on small businesses for its economic viability. The NMA also believes that to assure the survival of the health insurance industry, any state or federal mandate for them to accept "community rating" in their premium setting must be accompanied by a mandate on all citizens to purchase at least basic health insurance.

Several members of the NMA Health Planning Committee also serve on the Governor's Blue Ribbon Coalition to Study Health Care in Nebraska.[9] The NMA believes that the functions of this committee should be combined with that of the Interagency Health Care Advisory Committee of the State Health Department.[9] Such a body, which might be called the "Nebraska Commission on Health Care", should be adequately funded and staffed. The NMA further believes that a series of "town hall" meetings should be scheduled throughout the state, to provide grass roots input into the issue of health care reform, particularly in defining the "Basic Health Care" package. Since defining such a package is crucial to the whole process of health care reform, the NMA believes that only through such grass roots involvement can the agendas of special interest groups be in any way circumvented. Further, the NMA believes that individual physicians must remain the advocates of their patients, and that it is therefore not desirable nor proper for physicians to participate in the decision of what to include or exclude from a "Basic Benefit Package", except in an advisory capacity.

Summary

As the AMA has been on the cutting edge in discussions of health care reform nationally, so the NMA has been intimately involved in such discussions in Nebraska. As the "umbrella" organizations for physicians nationally and statewide, respectively, the AMA and NMA recognize that there is no easy and painless solution to the crisis. Indeed, there is still sharp division of opinion among medical specialty societies regarding even the most fundamental issues of health care reform.

From a state perspective, the NMA pledges to continue to work with other health care organizations, insurance organizations, and governmental entities to identify the health care reform measures that best suit the needs of the citizens of Nebraska, within the constraints that national health care reform will allow for individual state initiatives.

While physicians of Nebraska want a "place at the table" to discuss health care reform, it will be the challenge for the NMA to assure that physicians and the patients they serve do not become "part of the meal".

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VII. THE POSITION OF THE PROVIDERS

The Health Care Delivery System: Present Problems and Future Directions

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THE problems associated with the current fee-for-service health care system have been front page news for over a year, and many Americans rank healthcare second in importance only to the economy as a pressing issue. It is not hard to understand why this is the case.

Our healthcare costs are among the highest in the world but we are not achieving the results desired. We rank 15th in the world in life expectancy and 20th in infant mortality. We have over 36 million people without health insurance and millions more who lack adequate coverage. At the same time, healthcare represents 13% of the Gross National Product and is expected to exceed 18% in the year 2000. These costs are taking their toll on every segment of society.

Efforts to Control Healthcare Costs

Over the last ten years numerous efforts were made to decrease healthcare costs. Employers initiated managed care programs which include deductibles and co-payments for employees. HMO's and insurance companies moved from community rated to risk rated policies which also excluded, in many instances, individuals with pre-existing conditions. The federal government initiated a DRG program for Medicare recipients which provides fixed reimbursement to health care providers based on the medical diagnosis. In addition, working through Physician Review Organizations, the government spend millions of dollars on reviewing medical records to assure that the treatment of Medicare patients in a hospital setting was necessary and that the lengths of stay were appropriate.

On the state level, repeated attempts were made to control Medicaid expenditures, even as the numbers of Medicaid recipients continued to grow. One obvious result of these efforts to manage the care of those who are ill was a significant decrease in the numbers of people being served in the acute care hospital setting with a corresponding increase in outpatient services. In 1987 inpatient revenue comprised 80.4% of the income of Nebraska hospitals. By 1991, only 67.8% of income was derived from inpatient services. (Nebraska Hospital Association, Medicare Hospital Cost Report Data, 1993).

In the recent past, people went to hospitals to get well. They now come to be stabilized and are then moved to a skilled nursing facility or to their homes to continue the healing process. At the same time, many people who previously were served in the hospital setting are now receiving care on an outpatient basis. Currently 32.2% of Nebraska hospitals' revenues are derived from outpatient services. In 1987 the percentage of outpatient revenue was 19.6% (Nebraska Hospital Association Cost Report Data, 1993).

One obvious consequence of this trend from inpatient to outpatient services is that hospitals are now being filled with very sick, chronically ill people, many of whom are elderly. In addition, much of the space in acute care institutions previously used for hospital beds is now being used to provide outpatient services.

Impact on Healthcare Institutions

Efforts by the state and federal government, as well as by the private sector, to control healthcare costs have also dramatically decreased reimbursements to healthcare institutions.

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In fiscal year '93, Nebraska hospitals are projected to lose approximately $96 million from providing care to Medicare patients. That means, on the average, for every Medicare patient treated in the acute care setting, the hospital will lose $1,421.00 which is the difference between what it costs to provide the care and what the hospital will be reimbursed (NHA MONITOR, Volume XIV, Copy 45, November 7, 1992).

For Medicaid patients, as a result of the recent settlement of the Medicaid lawsuit in the state of Nebraska, hospitals will now be receiving a reimbursement of 85% of what it costs to provide Medicaid services. That's 85% of cost not billed charges.

Hospitals are also treating more patients who lack the resources to pay some or all of their bills. Those with high deductibles often do not have the money to pay the deductibles. Some have pre-existing conditions and cannot get insurance. Increasing numbers of people with little or no insurance are entering the hospital through the emergency room. Traditionally, hospitals have tried to cover these losses by charging more for those with insurance. With the advent of managed care and inadequate reimbursement for Medicare and Medicaid patients, it is impossible to cost shift in this manner.

Developing a New Delivery System

Given these current realities, it is obvious that the healthcare system as it now functions is not viable for the future. Hospitals and physicians must take the initiative in helping to recreate the system by developing new ways to deliver quality services at affordable prices.

The first step in this process is already beginning with efforts to move many of the outpatient services from the acute care setting into the community where they can be provided in a more cost effective manner.

The second step is to create economic incentives to keep people well; not simply care for them when they are sick. In this new model of delivery, financial reimbursement will be greater for those institutions and physicians who can prove though appropriate measures that the health status of those served has improved as a result of their services. This will necessitate a focus on disease prevention and health education as well as on the treatment of illness.

The third step will be to create new access points for health services in the community such as neighborhood health centers that are easily accessible and can provide a range of diagnostic and treatment services designed to keep people out of the acute care setting. These health centers will also place a high priority on the promotion of health care and the prevention of disease.

The fourth step will be the creation of Community Care Networks designed to provide the full range of health services, from prevention to long term care, in the most appropriate and cost effective settings. These networks will include healthcare institutions, physicians, mid-level practioners and insurance companies who are committed to improving health status, increasing the quality of services, and reducing costs. To be successful these networks will develop:

1. An organized continuum of services from prevention to long term care and home care with adequate linkages among the providers in the network;
2. A care coordination function that will ensure that patients receive the services needed in the most appropriate and cost effective health care setting;
3. Appropriate measures and practice protocols to ensure quality services and improve the health status for the enrolled population; and
4. Patient care information systems including computer link-ups, computerized patient records and the ability to move information across providers.

The final step in the process of re-creating the healthcare delivery system will occur when the Community Care Networks go "at risk" in accepting contracts to provide the whole range of health services from prevention and wellness to acute care and long-term care for a capitated payment. These networks will be able to succeed under capitation only to the extent that the healthcare institutions and the physicians work closely together to deliver the health services to the enrolled population in the most cost effective and appropriate setting.

Decisions for the Future

In order to create the Community Care Networks envisioned for the future, healthcare organizations will need to make some very significant decisons within the next two to three years.

One decision will be that of moving from an acute care hospital focus to a healthcare delivery system focus where the hospital is just one of a host of services within the system. Another important decision will be that of choosing the partners with whom to work in the network. This is a significant task because, in order to succeed, the networks will have to reduce excess capacity in the system and avoid unnecessary duplication of technology. As this happens it will become increasingly more difficult to break away from a network and "go it alone." The providers in the network will inevitably become more dependent on each other and their futures will be entwined with each other.

From my perspective the most important decision will be that of determining how and when to obtain physician involvement and input into the creation of the Community Care Network. It is obvious that physicians and healthcare organizations will need to work closely together to develop a managed care strategy for the future where capitation is the norm and not the exception. It is also obvious that physicians are integral to the network and need to be involved in decisions related to the location of neighborhood health centers and the recruitment of physicians and mid-level practioners to staff these centers.

I am still unclear, however, about the nature of the realationship that will exist between healthcare institutions and physicians in the future. Will physicians become salaried staff in the networks of the future? There certainly seems to be a thrust in this direction, particularly in regard to primary care physicians, in the literature that is developing around future networks. My bias, however, is toward the development of a true partnership relationship between physicians, healthcare providers and managed care plans. It seems to me that we sink or swim together. With all of us sharing equally in the risks, as well as the rewards, there is a real incentive to work closely together.

Conclusion

No doubt there will be many issues that will need to be resolved as we move toward the implementation of Community Care Networks. I am convinced, however, that this direction is necessary. If we are to succeed in our efforts to control health care costs we must move toward the integration of the financing and delivery of healthcare. We must also bring the economic incentives in line with the vision of keeping people well and not solely caring for them when they are sick. A community focused comprehensive delivery system is, I believe, the best model to respond to the current needs for change. It is also the best model to meet future healthcare needs in our society.

VII. THE POSITION OF THE PROVIDERS

Nebraska, The Health Care Good Life

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HEALTH care finance reform is clearly needed. Reform, however, which levels national costs will actually increase costs for states which have lower health care costs and quality reform already in place. Further, reform which brings unnecessary additional bureaucracy will increase costs and disempower health care providers.

Nebraska, and similar states, stand to be net losers in such proposals. According to the Employee Benefit Research Institute and reported in the Nebraska Hospital Association Newsletter, Nebraska has among the lowest cost per employee health insurance in the United States. Nebraska residents have faster access to far greater medical resources than do the citizens of Canada. The per capita cost for privately insured Nebraskans is far less than similar costs in Canada and less than half of those for publicly insured Americans. The percentage of Nebraskans currently uninsured is about the same as in Hawaii (9%) where employers are legally required to pay for employee health insurance. Following are the reforms which indicate Nebraska is the national health care leader:

Nebraska malpractice tort law was significantly reformed

Nebraska has the lowest malpractice premiums in the United States. Nebraska tort reform caps actual damages at $1,250,000 per person. In accordance with the Nebraska constitution, punitive awards go to the counties for the benefit of common education. The plaintiff and the plaintiffs attorney do not profit from penalties assessed against providers who lose in court. An Omaha based PPO reports that their Council Bluffs OB/GYN doctors pay three times what Omaha OB/GYN doctors pay for malpractice insurance. Doctors in Dade County Florida pay nine times more than Omaha, Nebraska doctors for malpractice insurance. These savings are certainly reflected in the comparatively low cost of Nebraska health insurance.

Every Nebraskan is insurable

Nebraska health care leaders created a working **Comprehensive Health Insurance Pool**. It guarantees that no Nebraskan will be denied coverage because of a preexisting condition. This coverage is not cheap but, it is similar in cost to prices for major medical insurance in many of the surrounding states. It is priced slightly higher (no more than 165%) than the cost of health insurance in the private marketplace.

Health insurance prices in Nebraska are limited

The Comprehensive Health Insurance Pool assures every Nebraskan that they can buy health insurance at a price slightly higher than the average major medical policy sold in the state. This price is below the price of standard health insurance in many, perhaps most, of the other states.

Insurance renewal premium laws in Nebraska have been reformed

Nebraska has provided underwriting reforms that limit rate increases for employer groups. Insurance plans in Nebraska may not single out anyone or any group for cancellation.

Insurance price competition is promoted in Nebraska

Nebraska regulations promote healthy competition creating lower prices. Hawaii's John Lewellen, Director of Hawaii Health Care reports that their problem is the stagnation in innovation caused by having only two dominant players, Kaiser Permanente' and Blue Cross. They are trying now to get more insurance companies to do business in Hawaii to create incentive to innovate.

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Special interest groups are controlled in Nebraska

Nebraska law prohibits special interest groups from affecting insurance pricing. In other states, it is popular for politically influential special interest groups to get their legislature to force health insurance to pay for their products or services. Examples of some of these special interest group reimbursement mandates are wigs, test tube pregnancies, marital counseling, massage therapy, acupuncture and hundreds of others. (If you want to buy health insurance in Minnesota, you must also buy toupee insurance.) These mandates create substantial health insurance cost increases.

Nebraska has a low uninsured population

Low health insurance premiums result in higher percentage (91% to 93%) of insured citizens. Health insurance prices are normally affected when providers are forced to shift non-reimbursed costs to those who pay for services. Nebraska health insurance premiums have felt the savings from a lower per capita uncompensated care cost shift.

WHAT SHOULD NEBRASKA DO NEXT?

Provide a low wage earner health insurance premium subsidy

This will assure every Nebraskan financial access. 7% to 9% of Nebraskans are uninsured. Most of them earn above the state poverty level and below 200% of poverty and cannot afford to buy health insurance. Nebraska must provide a subsidy for them to buy essential health care. Nebraska can effect the subsidy through a refundable tax credit or a voucher, administered by the Revenue Department and processed through the normal employer payroll process.

Create essential health care insurance

An affordable policy must be available to individual Nebraskans. It must be priced for those who earn below 200% of poverty so that it can be purchased entirely by the amount of the subsidy.

Systematically privatize Medicaid

It is important to put private capital at risk rather than potential taxpayer liability. Buy subsidizing low wage earners into the private sector, new entrants to the Medicaid system will stop. Cost shifting will be reduced and effective cost controls will be assured. A Medicaid waiver may become available to help fund the low wage subsidy.

Increase rural reimbursement levels in essential health care insurance

Increased rural funding to urban levels is inexpensive and will drive a substantial increase in rural services and health care capabilities. Arbitrary federal rural reimbursement rates have artificially limited the amount of capital available for quality care.

Require all payers to play by the same insurance rules and regulations

Certain benefit plans, most notably self-insured plans, are exempt from insurance regulations and state premium taxes. This creates inequity and artificial price disparity. Roughly one half of Nebraskans under the age of 65 are covered by self-insurance.

WHAT NEBRASKA SHOULD NOT DO?

Do not allow federally imposed monopolistic health care cooperatives

In an effort to manage costs, some planners suggest that competition can be managed by placing every provider into a cooperative or alliance wherein prices, patterns of care, access and benefits are set by federal regulation and controlled by bureaucracies. The idea is to pool a great number of employers to get large employer style discounts from providers. For the last two decades, small employers have been using such pools. They are called Multiple Employer Trusts (MET). Over 70% of small employers are already enrolled in MET's. If pooling works, moving small employers from one pool to another will have little impact on the large range cost of health insurance and will only serve to increase immediate administrative costs.

MET's are usually regional or even national in nature with prices adjusted for geographic cost experience. The nature of MET's makes them more economically viable for rural American than the local "Health Alliance" idea.

IN CONCLUSION

Nebraska should look to its own leadership for immediate reforms while fending off many of the national proposals. Nebraskans must call for federal tax reform to change from a subsidy that rewards higher wage earners for employer paid health insurance while refusing subsidy to those who most need it. The federal government spends $80 billion each year sending health insurance purchase subsidies to the wrong people. Through the current system, Nebraskans subsidize the purchase of health insurance in other states. If this inequity alone were resolved, every Nebraskan could afford insurance to cover quality health care.

VIII. THE FUTURE OF REFORM

The Future Of Health Care Reform

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THE presence of any legislation presented to Congress by the President has a unifying effect on the party in power. Certainly this will be the case in an issue so strongly contentious as health care. Each American, whether insured or not, will have an immediate impression about our system and whether or not it needs major correction. However, this President has been elected without a majority of the citizens and, even now, does not have widespread voter confidence. This apathy will be reflected in the rebelliousness within his own Democratic party. One needs only to reflect upon the closeness of votes on the budget, or the changes made in Congress regarding the issue of homosexuals in the military, to see that having a majority of members in a party does not necessarily deliver an enacted piece of legislation.

The majority of Americans feel much of the cost of medical care is due to waste, fraud and abuse of the system. High hospital costs, exorbitant physician charges, insurance company abuses, and misuse of the federal programs are frequently cited. While each of these issues will play their political part in health care reform, the overriding reason for the federal government to change the system is to control the deficit. Clearly, the uncontrolled rise of spending in Medicare and Medicaid has been the major factor in the rising deficit. Without containment of these two programs there cannot be effective deficit reduction.

Unfortunately for our political leaders in Washington, decreasing spending for Medicare will bring about swift and effective retribution from the well organized senior citizens who vote frequently and in large numbers. Most experts believe the projected cuts in Medicaid and Medicare proposed by the President are completely unrealistic and will not be approved by Congress. In effect, President Clinton has told Congress to either approve his funding or come up with a different source. The President is unlikely to unilaterally suggest raising taxes in view of his recent problems with the budget legislation.

The Republican response will probably be to suggest that 85% of Americans are already insured, and the rest could be covered by less regulatory means. Their ideas regarding restructuring the insurance industry have gained considerable acceptance. This Republican response of regulatory overkill will undoubtedly be effective particularly if the fiscal projections for President Clinton's plan prove to be untrue.

Once the Health Security Bill is placed on the floor of the Congress, there are at least 12 committees that may have jurisdiction. That is, each of these will schedule committee meetings and public hearings regarding each part of the legislation. The key committees are the House Ways and Means, Health and Labor, and the Senate Finance Committee. Failure to move out of these committees will doom the legislation.

Another threat to this legislation is the presence of several other plans, both Democratic and Republican, that have been introduced. While the President's plan will gain the most press coverage, the presence of other legislation will require Clinton's Health Security Act to incorporate portions of the competing plans in order to gain votes. The depth of this problem is to note that 89 House members have co-sponsored single payer system legislation.

The President's bill will have several areas that are potential deal-breakers. These will include the employer mandate, slowing of Medicare costs, and the highly regulatory framework of the National Health Board.

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The merits of an employer mandate will be a major battleground between the Administration and Republicans and conservative Democrats. This is a philosophical difference of opinion; but politically, President Clinton must have mandated coverage unless he is willing to raise large amounts with new taxes. The President is unlikely to compromise on such a basic issue unless he is willing to not guarantee universal coverage.

Similarly, the regional alliance will be highly contentious. Originally intended only for small business insurance, the Administration has limited the ability of any sized company to remain outside the system. If remaining outside the alliance becomes difficult, effectively the United States will have a national health care plan run by a central administration, the National Health Board.

The Health Security Act leaves little latitude for state innovation; however, Nebraska is well on its way to developing a plan that would satisfy the needs of our state. There will be adequate time for input from both health care professionals as well as consumers. Results of the Blue Ribbon Coalition and InterAgency Task Force will soon be amalgamated into a single form, and a single plan will eventually be developed.

The Health Security Act is unlikely to pass without major change. Since insurance companies, pharmaceutical companies and hospitals and physicians are likely to bear the brunt of cost containment strategies, they will be important participants in this initiative. While Hilary Rodham Clinton has been an effective leader in formulation of the package, its passage will ultimately be determined by the individual constituencies of the Congressmen and Senators. Physicians remain the most important portion of the health care system and will demand a strong voice in determining the final plan. Each of us should remain well informed and let our feelings about any reform be known to our elected representatives.

What if no legislation in a comprehensive form passes? Already we, as providers, have seen the rapid and comprehensive shift of insurers, hospitals and physicians in adapting to the future of health care in America. Such change will continue either with or without legislation. Physicians need to add their constructive voices as the ultimate care givers for patients throughout our state and country.

EDITORIAL

RBRVS: Unfinished Business

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One of the primary reasons for implementation of the Resource Based Relative Value Scale (RBRVS) was to create a more level playing field by removing the financial incentives that have encouraged physicians to enter highly technical and procedure oriented specialties. This was to be accomplished by establishing a system in which the physician is reimbursed based upon the cost of resources used to deliver a particular procedure or service. Practice expenses (41% of the RBRVS) are not resource-based, but still based upon historical charges. This results in an inequity where many surgical procedures are systematically over-valued while primary care and other evaluation and management services remain under-valued. A primary care provider must provide 75 new patient (level 3) office visits to equal the practice expense assigned to one coronary artery bypass procedure under the current historical charge system. This is particularly troubling in light of the fact that the bulk of a surgeon's overhead for this procedure is paid for by the hospital.

The provision directing the Department of Health and Human Services to develop a methodology to base all practice expense relative value units (RVUs) on resource costs was dropped from the budget reconciliation bill because it violated the Senate Byrd Rule. Primary care providers and many other office-based physicians were very disappointed that parliamentary rather than policy considerations forced the demise of the resource based practice expense methodology provision in OBRA '93. OBRA '93 contains a provision to cut "over-valued" practice expense RVUs but the budget bill's inclusion of practice expense cuts without mandating a resource-based practice expense methodology will have a detrimental effect on evaluation and management oriented physicians.

Inequitable payment schemes are leading to frustration within the evaluation and management physician community. It has become increasingly difficult to recruit physicians into evaluation and management oriented practices such as family practice, general internal medicine, and non-procedural subspecialties because of existing payment inequities. Mandating a resource-based practice expense methodology will provide a necessary financial incentive for medical students to look past procedurally-based specialties and investigate what evaluation and management practices have to offer.

Basing practice expenses on resources has received substantial support in and outside of Washington D.C. The measure was included in both the Senate and House Energy & Commerce versions of the Reconciliation Bill and President Clinton called for it in his initial budget proposal. The Physician Payment Review Commission recommended to Congress that practice expenses be based upon resources and not historical charges. It is unfortunate that a mandate for HHS to develop a methodology to base all practice expense RVUs on resource costs was dropped from OBRA '93 because of a technicality. I urge each of you to contact your congressman and senators urging them to draft legislation mandating the Department of Health and Human Services to develop the methodology for implementing a Resource Based Practice Expense Component as soon as possible and preferably before full implementation of the RBRVS occurs in 1996.

PERINATAL PAGE

HELLP Syndrome: A Variant of Severe Preeclampsia

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The University of Nebraska College of Medicine, Omaha, NE

HYPERTENSION complicates approximately 9% of pregnancies. The majority of these hypertensive women have pregnancy induced hypertension or preeclampsia. Certain populations, including primigravidas and those of lower socioeconomic status, are at increased risk for the development of this disorder. Other risk factors include women at the extremes of reproductive life, obesity, nutritional deficiencies, prior history of hypertensive disease, underlying renal or vascular disease, and multiple pregnancy.

Many authors attempt to distinguish pregnancy induced hypertension from preeclampsia. In reality, it represents a continuum of the same disease process. Commonly accepted criteria for diagnosis of pregnancy induced hypertension include an absolute blood pressure of 140/90 or a 30 mm increase in systolic or a 15 mm increase in diastolic blood pressures. These elevations should be persistent, defined as two (2) separate elevations at a minimum interval of 6 hours. Non-dependent edema (hands and face) and proteinuria (300 mg or more in a 24 hour collection) are additional criteria of preeclampsia.

Patients with preeclampsia at term require delivery, generally under seizure prophylaxis with magnesium sulfate. Mild preeclampsia occurring remote from term is frequently managed expectantly with increased bed rest and frequent outpatient visits. In many institutions, preterm patients with mild preeclampsia are admitted to the hospital for an initial period of observation and laboratory assessment.

The patient with preeclampsia who develops severe hypertension (defined as a blood pressure of 160/110 or greater) should be evaluated for delivery. Additional criteria include the development of end-organ involvement as manifested by elevated liver enzymes, worsening proteinuria, and low platelets.

A unique subset of patients with severe preeclampsia is the subject of this discussion. HELLP Syndrome is an eponym indicating the cardinal features of this disease which include: HE-hemolysis, EL-elevated liver enzymes, and LP-low platelets. This syndrome was originally described by Weinstein in 1982. The majority of clinicians feel that HELLP syndrome is a variant of preeclampsia and its presence requires consideration for delivery. Mild degrees of elevated liver enzymes and modest thrombocytopenia can occur in patients with mild preeclampsia and are not an absolute indication for delivery. A more reasonable approach is to establish criteria for the three features of this disease. Table 1 demonstrates commonly used criteria for a diagnosis of HELLP Syndrome.

It is important to recognize that HELLP Syndrome can occur against a background of otherwise mild preeclampsia. Many patients with this disease may not appear clinically ill and have only modest degrees of hypertension. Some patients will develop symptoms suggestive of severe preeclampsia, such as headache and epigastric pain, but these features are not required for a diagnosis of HELLP Syndrome.

When faced with a patient who appears to have otherwise mild preeclampsia and who meets criteria for HELLP Syndrome exclusion of other diseases is necessary. Table 2 lists diseases to consider in the differential diagnosis of this syndrome. Many patients with these disorders will have a chronic history of disease in question and therefore can be excluded from having HELLP syndrome.

Management considerations in patients with this disorder are listed in Table 3. There is no contraindication to trail of labor in patients with this disorder. Patients who demonstrate wors-

*Address correspondence and reprint request to: Carl V. Smith, MD, Dept. of OB/GYN, 600 South 42nd Street, Omaha, NE 68198-3255, phone: (402) 559-6150, FAX: (402) 559-5015.

TABLE 1
Laboratory criteria for HELLP Syndrome

1. Thrombocytopenia-platelet count below 100,000 per cubic mm
2. Hemolysis - lactic dehydrogenase (LDH) above 180 International units per liter
3. Astaspartateaminotransferase (AST) above 50 International units per liter.

TABLE 2
Differential diagnosis of HELLP Syndrome

1. Acute fatty liver of pregnancy
2. Viral hepatitis
3. Bud Chiari syndrome
4. Pancreatitis
5. Idiopathic thrombocytopenic purpura
6. Systemic lupus erythematosus
7. Cholecystitis
8. Hemolytic uremic syndrome

TABLE 3
Management of HELLP Syndrome

1. Establish the diagnosis
2. Exclude other disease processes in the differential diagnosis
3. Seizure prophylaxis with magnesium sulfate
4. Maintain normal urine output ($\geq$ 30 cc per hour) and blood pressure of < 160/110
5. Assure fetal well-being
6. Induction of labor

ening clinical condition, an unfavorable cervix, or who are markedly preterm may be candidates for a primary Cesarean delivery.

Platelet transfusions are required infrequently. Spontaneous hemorrhage can occur with platelet counts below 20,000 and platelet transfusions are recommended in patients with a platelet count of 50,000 who require Cesarean Delivery. Patients whose platelet counts are above 50,000 usually tolerate vaginal delivery or Cesarean section without the need for platelet transfusions.

After delivery, magnesium sulfate seizure prophylaxis should be continued for at least 24 hours. Some patients may require several days to resolve the clinical stigmata of their disease. Discharge from the hospital can be accomplished when platelet counts begin to increase and liver enzymes begin to normalize.

In summary, HELLP Syndrome is a frequent complication of preeclampsia. When it occurs, a diagnosis of severe preeclampsia is made and preparations for delivery should be undertaken.

1. Are there antitrust rules that absolutely prohibit collaborative efforts among or between health care providers?

No. However, an agenda should first be set and guidelines followed. Such meetings, even if not resulting in improper agreements, can provide problems if activities following such a meeting suggest the parties condoned activities prohibited by antitrust laws.

These guidelines should be followed:

1. Certain collaborative activities that service the community, such as indigent care, do not affect competition and are permissible.
2. Collaborative efforts should be reviewed to see if they would tend to restrict rather than enhance competition; for example, a joint MRI effort which creates a new service which no single health care provider could have provided alone, and which enhances competition with other communities where MRI services were being provided.
3. If the collaborative effort would restrict price competition or allocate patients or divide service areas, it can be assumed the activity violates the antitrust laws.
4. If the items in Paragraph 3 above are not present, procompetitive elements of the collaborative effort may well exceed the anti-competitive elements. This test is assisted by the "rule of reason." The procompetitive elements need to be recorded and documented.
5. With respect to proposed joint ventures, health care providers need to determine if those proposing the ventures are presently competitors; determine the effect of the joint venture on competition; determine the purpose of the joint venture; and finally determine whether the ultimate aim of the joint venture can be effectuated without anticompetitive overtones.

2. Is there a list of antitrust activities that are permissible and non-permissible?

It is difficult to reduce antitrust concerns to an outline, but here are a few "do's and don'ts" for physicians, associations, medical societies and health care institutions:

1. Do not make agreements or concerted action among other institutions or physicians to affect prices (raising, lowering, fixing, pegging, etc.)
2. Do avoid discussing fees with other institutions or with other physicians' practices or engage in any group activity that would have an impact on competition.
3. Do not be involved in group boycotts or concerted refusals to deal which are collective actions to coerce or exclude others from a market. A refusal by one person or entity can be, however, lawful if the refusal is not in furtherance of any other anticompetitive purpose.
   - Do not do anything to prevent physicians and institutions from participating in the operation of a group health plan or from assisting local HMO's; cannot exclude HMO physician from staff for reason of HMO affiliation.
   - Do not jointly refuse to deal with an HMO, or jointly refuse to refer patients to a certain plan.
   - Do avoid coercion and intimidation.
4. Do not create illegal tying arrangement such as conditioning staff privileges on use of institution equipment, etc.
5. Do not agree with competitors to divide markets or allocate customers among themselves.
   - "You take north of "O" Street, I'll take south" is illegal.
   - Under CON procedure, it is permissible for an institution, physician or medical society to address the issues to the governmental body (executive, legislative and judicial).
6. Do not monopolize, conspire or attempt to monopolize.

- Can apply to acquisition of one institution by another in the same area, if competition substantially lessened or monopoly created.

7. Do not be involved in group buying or shared services unless reduced prices to members are cost justified by the seller. Must have valid distribution function.
8. Do assume that informal oral agreements are subject to the antitrust laws.
9. Do assume that unilateral actions are not subject to the antitrust law. A single institution or individual physicians or physicians practicing in groups can take independent actions.
10. Do engage in good faith peer review.
11. Do not engage in credentialing for competitive purposes.
12. Do assume an institution, individual physician or medical society can lobby the Legislature to increase reimbursement levels.
13. Do assume a physician can individually (or by office) refuse to participate in a third party payer program.
14. Do assume joint ventures among institutions and/or physicians are permitted if they are procompetitive.
15. Do assume an association or a medical society can ask legislatures, courts and government agencies in good faith for any action including economic, as long as institutions or physicians as a group do not threaten not to participate if requests are denied.
16. Do assume an association or a medical society can advise members with respect to third party payer proposals so long as the decision to participate is left to individual physicians.
17. Do assume an association or a medical society can express concerns of members and recommend changes with respect to third party payer proposals, if there is no threat of concerted action if changes are rejected. This includes procedures, services, forms, peer review procedures, etc.
18. Do assume an association or a medical society can express views of members that fees or reimbursement levels are too low, as long as there is no threat of refusal to participate if the requests are not met.
19. Do assume an association or medical society can participate in peer review programs with respect to individual fee reasonableness. Decisions on these matters should not be generally disseminated to physician members, and discipline of members on these issues should be avoided.
20. Do not assume an association or a medical society can develop a fee schedule.
21. Do assume that fee information can be collected by an association or a medical society for purposes here stated, but do not assume the information can be disseminated to competing institutions or physicians or members generally.
22. Do assume an association or a medical society can meet, discuss and respond to a third party payer's reimbursement proposal, provided there is no threat of boycott and each institution or physician or group practice independently decides whether or not to participate.

3. What were the recent Federal Government rules announced that relaxed antitrust guidelines for health care providers?

On September 15, 1993 the U.S. Attorney General and the Federal Trade Commission issued six policy statements which address (1) hospital mergers; (2) hospital joint ventures involving high technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchange of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures. Of these, number 6 is most important to physicians. In part, it provides the agencies will not challenge, absent extraordinary circumstances, a physician network joint venture comprised of 20% or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk. Physician network joint ventures comprising more than 20% of physicians with active staff privileges at a hospital will probably not be challenged. The same is true with respect to a physician network joint venture with a large market share in a relatively small community.

Space does not permit a more detailed analysis of these often complex issues. Consultation with counsel is advised for further information.

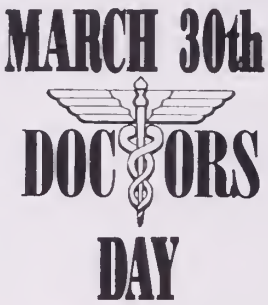
***

"Ask a Lawyer" is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen Jr. of the Cline Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

ALLIANCE

Doctors' Day

BARBARA J. PECK
Doctors' Day Chairman



March 30th has been designated as National Doctors' Day to pay tribute to Doctors for their dedication to providing quality health-care. The first Doctors' Day observance was held on March 30, 1933 in Barrow County Georgia. The day was chosen to honor Dr. Crawford W. Long's use of sulphuric ether in a surgical operation for the first time in medical history (1842).

Doctors' Day affords us the opportunity to say thank you to our Nebraska Physicians. The state theme for Doctors' Day 1994 is "DOCTORS GIVE MORE TO THEIR COMMUNITIES THAN GOOD MEDICAL CARE." Across our state, physicians are serving as volunteers in a number of various activities. This gift of time and energy helps to enrich the lives of people in our communities.

It would be interesting to take a survey of the type of volunteer activities and the time commitment given by physicians and their spouses in our state. We have all heard the statement that volunteers are healthier people. As we look to celebrate Doctors' Day in Nebraska, it is a good time to reflect in our schedules and put finding a balance in our lives a priority.

PHYSICIANS OF NEBRASKA WE SALUTE YOU!!! We know that you are making a difference in this world. Thank you for your day-to-day work and for your dedication to caring for others.

NMAA WALK/RUN

On Saturday, April 16, 1994 the Nebraska Medical Association Alliance in conjunction with Make-A-Wish Foundation of Nebraska is planning a statewide Walk/Run.

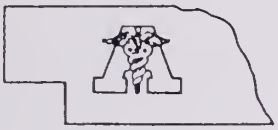
Because of the climate of health system reform and with so much focus currently placed on medicine, NMAA has chosen this state-wide project to identify health care providers and their families as caring participants in charitable endeavors, particularly in the comfort afforded the terminally ill child. We hope this project will give the many county alliances some cohesiveness by working towards a common goal.

Omaha, Lincoln, Hastings, Grand Island, Kearney and Scottsbluff Alliances have expressed their interest in being part of the Walk/Run. Each Alliance will determine the type of event it will sponsor. Co-chairmen, Cyndi Munyon and Linda Schafer with the help of the Omaha division of Make-A-Wish will coordinate many of the efforts.

It is our hope that this concept of statewide unity in the medical community and the desire to make some wishes come true for our terminally ill Nebraska children will prompt you to become involved in this project. Please join us as "partners" in this endeavor.

Chairmen:
Cyndi Munyon and Linda Schafer

SALUTE TO MEDICAL DOCTORS' DAY



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COMING MEETINGS

UNIVERSITY OF NEBRASKA MEDICAL CENTER MEDICAL EDUCAATION

11 DAYS, MARCH 14-25, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY - SATURDAY, APRIL 14-16, 1994 — 2nd Annual Diagnostic Dilemmas in Women's Health Care, Marriott Hotel, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Fee: $200.

11 DAYS, APRIL 18-29, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY-FRIDAY, JUNE 12-15, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Obstetrics and Gynecology, Oncology/Hematology & Researchers.

THURSDAY-SATURDAY, JULY 14-16, 1994 — 1994 National Conference on Family Violence: Research and Practice, Holiday Inn Centre, Omaha, Nebraska. Target Audience: Multidisciplinary (health professionals, sociologists, criminal justice)

TUESDAY-FRIDAY, JULY 19-22, 1994 — Pan Pacific Lymphoma Conference, The Ritz Carlton - Mauna Lani, Kohala Coast, Hawaii. Target Audience: Oncology/Hematology & Researchers.

FRIDAY-SUNDAY, AUGUST 19-21, 1994 — Imaging and Breast Cancer, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians.

MONDAY, SEPTEMBER 26 - SATURDAY, OCTOBER 1, 1994 — Emergency Medicine, 1994, Skills and knowledge for the Practicing Physicians, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuting Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

MAYO FOUNDATION

OCTOBER 23-27, 1994 — Advances in Diagnostic Radiology, The cloister, Sea Island, Georgia. Registration fee: $595, 22.5 credit hours in Category 1 AMA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688.

CREIGHTON UNIVERSITY

APRIL 3-9, 1994—Anesthesiology Review Course - Professional Seminars - Orlando, FL.

APRIL 4, 1994 — Medical Complications - OB Outreach Program at Offutt Air Base, Omaha, NE.

APRIL 15, 1994 — Distinguished Lecture Series - Henry J. Mankin, M.D. - St. Joseph Hospital Seminar Room.

APRIL 22-23, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

MAY 2, 1994 — Abruptio Placenta - OB Outreach Program at Offutt Air Base, Omaha, NE.

MAY 19-22, 1994 — A Review of Orthopaedics and Orthopaedic Pathology - Criss II Building, Creighton University, Omaha, NE.

MAY 27-29, 1994 — Family Medicine Update, Okoboji, IA.

JUNE 6, 1994 — Medical Therapy of the Fetus - OB Outreach Program at Offutt Air Base, Omaha, NE.

JUNE 29, 1994 — Couple to Couple League - "Natural Family Planning: The Time Has Come" - St. Joseph Hospital, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

AUGUST 12-13, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 2500 California Street, Omaha, NE 68178.

OFFICE OF CONTINUING MEDICAL EDUCATION
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THURSDAY, JUNE 17, 1993 • State of the Art Clinical Symposium on Allergic Diseases, Location: The Ritz-Carlton Hotel, St. Louis, Missouri, Program Chairman: Phillip E. Korenblat, M.D.

FRIDAY-SATURDAY, September 10-12, 1993 • Frontiers In Endosurgery: Advances in Endourological Techniques and Technology, Location: Washington University Medical Center, St. Louis, Missouri, 18.5 credit hours AMA Category 1, Program Chairmen: Ralph V. Clayman, M.D. and Elspeth McDougall, M.D.

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THURSDAY-FRIDAY, APRIL 21-22, 1994 — Symposium On Obstetrics & Gynecology, Location: St. Louis, Missouri.

FRIDAY-SUNDAY, JUNE 24-26, 1994 — Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862 Interstate, (314) 362-6893 In Missouri, FAX (314) 362-1087.

UNIVERSITY OF KANSAS MEDICAL CENTER

APRIL 15-17, 1994 - 44th Annual Postgraduate Symposium on Anesthesiology, Ritz-Carlton Hotel, 401 Ward Parkway, Kansas City, MO. Sponsor: Dept. of Anesthesiology, University of Kansas Medical Center. Target Audience: Anesthesiologists, nurse anesthetists, family physicians. Fees: To be announced. Credit: AMA Category 1 of the Physician's Recognition Award: 16.5 hours American Academy of Family Physicians: to be announced, American Association of Nurse Anesthetists: to be announced, American Nurses Association: to be announced.

Contact: Office of Continuing Education, KU Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160-7108.

AMA NEWS NOTES

(continued from page 15A)

The AMA does not support federal mandates over graduate medical education that would require a ratio of primary care to non-primary care physicians.

Dr. Duvall called for reforms to the Employee Retirement Income Security Act, stressing that all employee health benefit plans — both insured and self-insured — must offer a standard set of benefits meeting federal guidelines.

He also spoke out on the physician payment issue, stressing a vigorous fee-for-service sector "must be a central feature of health system reform."

* * *

AMA TESTIFIES ON COVERAGE FOR UNINSURED

The AMA emphasized its commitment to achieving universal health coverage and gave a congressional panel recommendations for attaining that goal.

AMA Trustee Raymond Scalettar, MD, testified before the Senate Finance Committee Feb. 10 at a hearing on "Health Care Access and Coverage for the Uninsured."

During a vigorous question-and-answer period, Sen. Jay Rockefeller (D, W.VA.) harshly criticized the AMA for "backing away" from the employer mandate.

Dr. Scalettar assured Rockefeller and others on the committee that the AMA had not "backed off" the employer mandate but had merely added an individual mandate to the list of financing mechanisms the AMA finds acceptable.

He pointed out that when the AMA's Health Access America was first developed, the notion of an individual mandate was not in the health system reform lexicon.

* * *

AMA CHAIR STRESSES CALL TO ACTION AT LEADERSHIP MEETING

AMA Board Chair Lonnie R. Bristow, MD, called on 1,000 medical leaders attending the leadership meeting to boost the Association's new massive grass-roots campaign.

He asked them to "speak out against the forces that would split us apart."

Speaking at the AMA's National Leadership Conference in San Francisco Feb. 11, Dr. Bristow asked the Federation to support the AMA's "proposal for action," launched Jan. 24.

It calls on Congress to pass a bill that ensures extensive physician involvement in a reformed health system.

"Our game plan is based on the power of local politics," Dr. Bristow said.

"We're calling upon thousands and thousands of doctors, just like you, to be the lightning rods of reform in your own communities.

"Let Congress know that no system will succeed without the full engagement of physicians as advocates for our patients and for our profession."

* * *

NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

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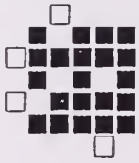

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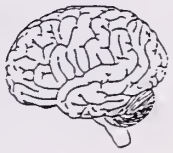

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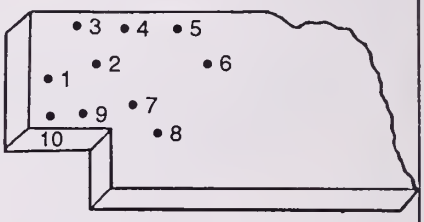

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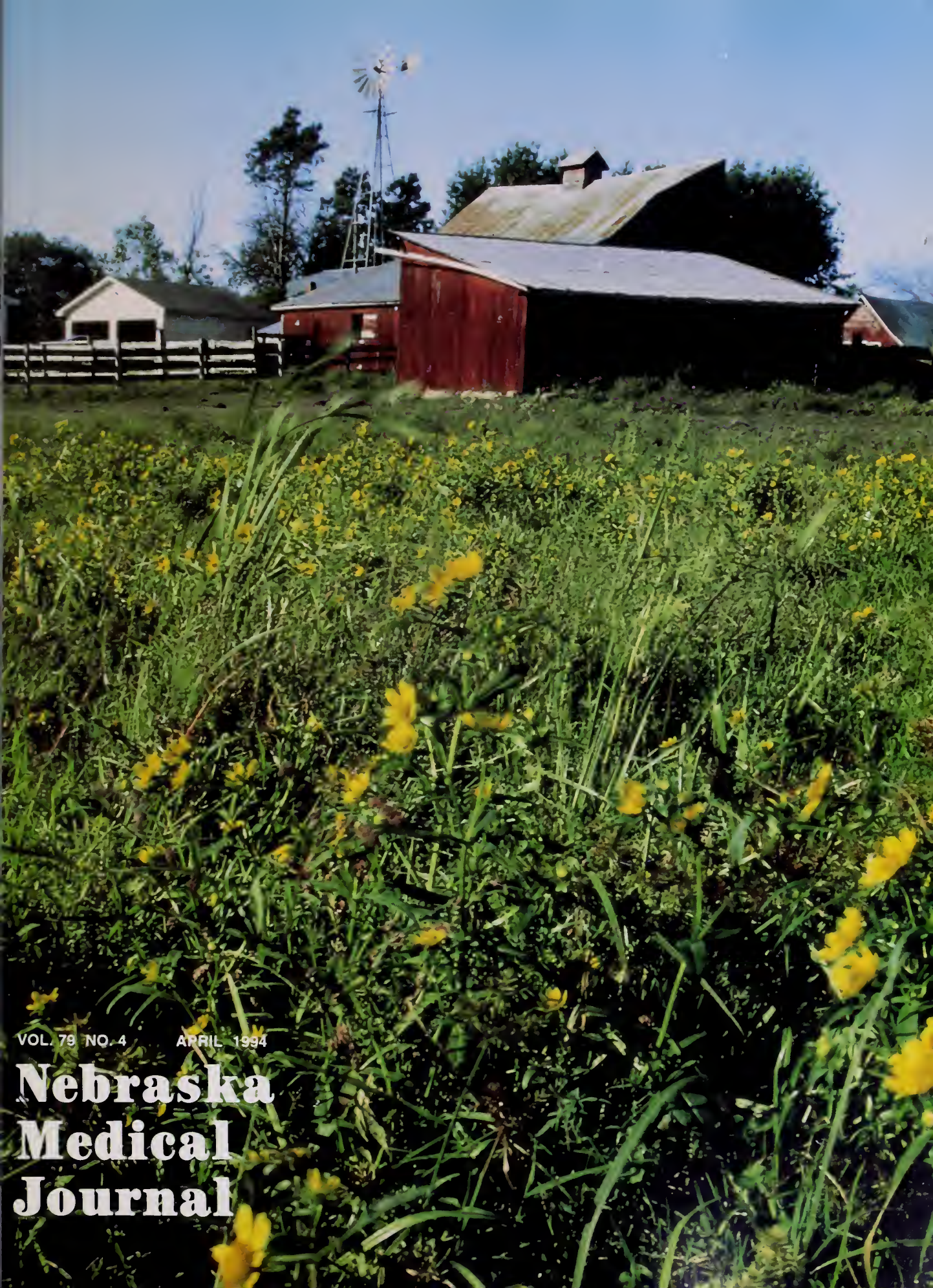

VOL. 79 NO. 4 APRIL 1994

Nebraska Medical Journal

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Treating Cancer Takes Teamwork

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The Nebraska Medical Journal

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""A TOUCH OF YELLOW"
Photography by Mary Alice Jones
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† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03)

Please see following page for brief summary of Prescribing Information.

CLARITIN®
brand of loratadine

TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the ECG on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks to 6 months duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN
PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients:

Autonomic Nervous System: Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole: Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System: Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System: Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System: Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System: Arthralgia, myalgia.
Psychiatric: Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System: Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System: Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages: Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System: Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema, abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis, alopecia, seizures, breast enlargement, erythema multiforme, and anaphylaxis.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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Reference
1. Bédard P-M, Del Carpio J, Drouin MA, et al. Onset of action of loratadine and placebo and other efficacy variables in patients with seasonal allergic rhinitis. Clin Ther. 1992;14:268-275.

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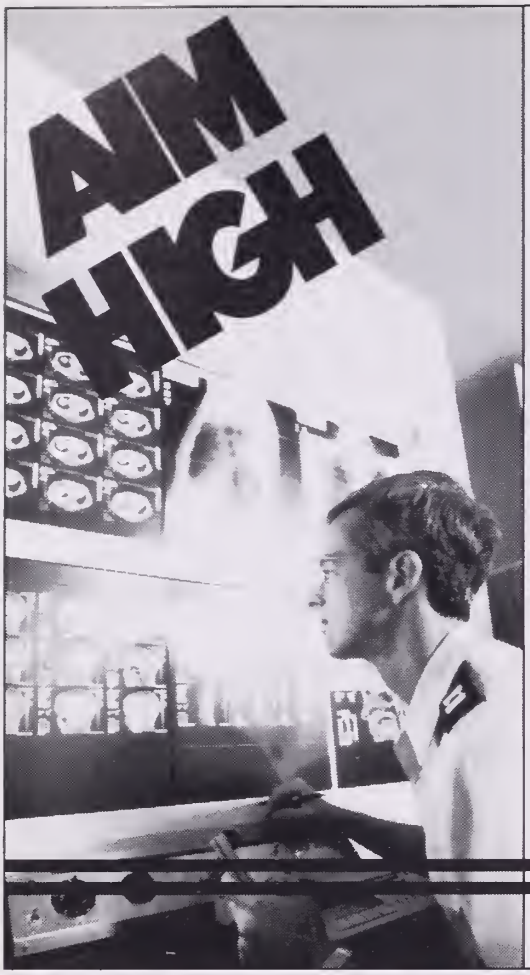

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The Hospital Medical Staff Section
23rd Assembly Meeting
June 9-13, 1994
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Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
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AMA NEWS NOTES

MEDICINE TAKES MESSAGE TO WASHINGTON

The physicians of America are in agreement on the basic goals of health system reform, and it is time for Congress to move ahead toward those goals.

This is the message the AMA's March 7-9 event in Washington, D.C., "Partnership for Action: Uniting for America's Health," sent to Congress, the White House and the media.

"We are here on behalf of the 90% of the nation's physicians who agree with our goals for health system reform but who are in their home towns treating patients," said AMA Board Chair Lonnie R. Bristow, MD.

"We are standing up and speaking out for just about every physician in America . . . American physicians are speaking with a single voice — it's not your voice or my voice — it's our voice."

As Dr. Bristow made these comments, representatives from every state medical society assembled beside him, symbolizing the profession's unified support for enactment of health system reform.

More than 800 physicians attended the meeting. Each wore a "Voice + Choice + Coverage" button identifying the key elements of AMA's reform principles.

* * *

NEWSPAPER ADS PROCLAIM UNITY OF PROFESSION

Full-page advertisements headlined "We Agree" appeared in the March 8 editions of *The New York Times, Wall Street Journal, Washington Post and USA Today.*

The ad featured a unity letter outlining medicine's criteria for effective health system reform endorsed by all 50 state medical associations and the District of Columbia, 64 medical specialty societies and the AMA.

These physician groups, representing more than 600,000 physicians and medical students, said that any system reform measure adopted by Congress should include:

1. Universal coverage, with financial responsibility shared among employers, individuals, and government.
2. Freedom for every American to choose his or her own health plan, physician and other health care providers.
3. More physician involvement in restructuring the system, keeping medical decision-

(continued on page 14A)

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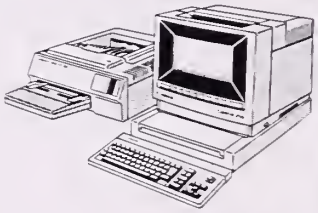

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AMA NEWS NOTES

(continued from page 13A)

making in the hands of physicians and patients.

4. Protection of the patient-physician relationship from the spreading corporate and government domination of health care.
5. Competition in the marketplace to slow the increased rate of health care spending.
6. Elimination of needless bureaucracy.
7. Professional liability reforms that cap non-economic damages, limit plaintiff attorneys' fees, and minimize defensive medicine.

The ad also stressed physicians must have direct involvement in a reformed health system to better serve the interests of their patients.

* * *

AMA LEADERS CALL ON CONGRESS TO ACT

At a March 8 press conference during the "Partnership in Action" meeting, AMA Board Chair Lonnie R. Bristow, MD, reiterated the medical profession's commitment to reform.

"Doctors and patients want Congress to set aside partisanship and create new legislation that provides health care for everyone," he said." At the same time, Congress must build stronger professional and patient involvement into the system itself to balance the growing domination of giant insurance companies and for-profit corporations whose focus is on the bottom line."

"While each proposal opens a door to reform, currently no single plan will get the job done. It's time for a fresh start and a strong finish."

* * *

MEMBERS OF CONGRESS HEAR FROM PHYSICIANS

The "Partnership in Action" event gave many physicians an opportunity to meet with their representatives in Congress.

On Monday evening, March 7, a series of dinners drew 71 members of Congress to the Stouffer Mayflower Hotel to meet with their physician constituents.

On Wednesday morning, participants were briefed by the AMA Washington staff before heading off to Capital Hill to meet with their congressional representatives.

Ten members of Congress who are sponsors of health system reform legislation spoke at the meeting: Sens. John Chafee (R, R.I.), Robert

(continued on page 15A)

Dole (R, Kan.), Phil Gramm (R, Texas), Orrin Hatch (R, Utah) and Edward Kennedy (D, Mass.), and Reps. Jim Cooper (D, Tenn.), John Dingell (D, Mich.), Newt Gingrich (R, Ga.) James McDermott, MD (D, Wash.) Roy Rowland, MD (D, Ga.)

They were preceded on the platform by Eleanor Clift, White House correspondent for *Newsweek* and Fred Barnes, senior editor of the *New Republic*. Clift commented that there was an emerging consensus in Washington that the "status quo won't do." She pointed to a growing willingness in both parties to compromise and predicted legislation could be enacted by October.

Barnes said the original Clinton bill was in serious trouble because "People don't like it," and stated that the White House must be willing to compromise or no legislation will be enacted this year.

Speaking on behalf of the Clinton administration, Dingell said, "We have to control costs. In a Japanese car, about $200 to $500 goes for health care. In the United States, it's about $1,800 per car." Kennedy called comprehensive coverage the "cornerstone of real reform," and insisted that some type of employer-mandated coverage is necessary.

From the Republican side, Gramm stated, "Let's fix what's broken without destroying the greatest system in the world. Speak on behalf of the person who hasn't been heard from in this debate — speak for your patients."

Congressional speakers outlined highlights of their bills. Two common themes: a degree of optimism that legislation would be enacted in this session of Congress, and an awareness that a great deal of compromising will be necessary if any bill is to win final approval. As McDermott commented, "This is the time to send your message to Congress."

His concern was echoed by AMA EVP James S. Todd, MD: "We must make our voice heard. This is truly the moment of truth. We have the best chance in our lifetime to fix the problems of the health system."

* * *

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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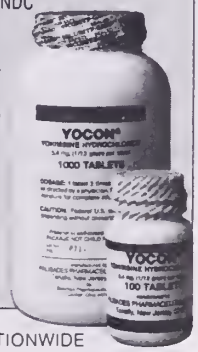

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Bus. Phone ( )	Income $	No. of years	
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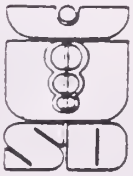

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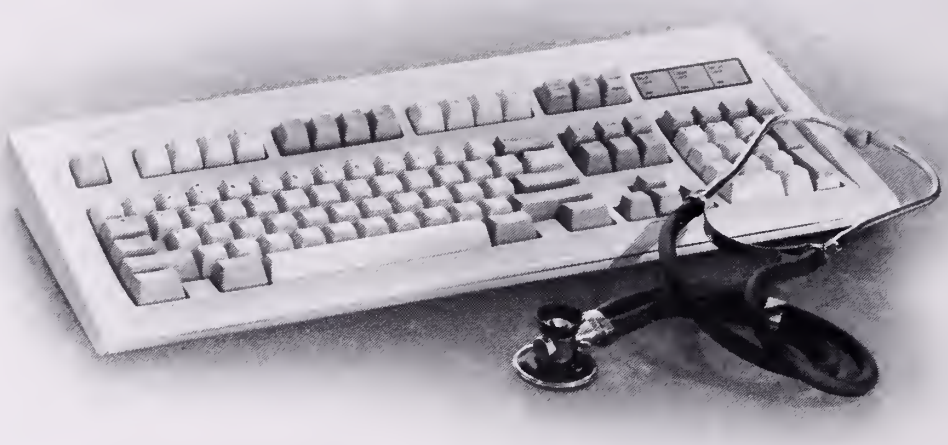

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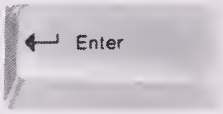

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126th ANNUAL SESSION

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6:30 p.m. — Inaugural Ceremony
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Saturday, April 30, 1994
Marriott Hotel, Omaha, Nebraska

THE NEBRASKA MEDICAL ASSOCIATION
126th ANNUAL SESSION

DOMESTIC AND ADOLESCENT VIOLENCE

9:00 a.m. — Plenary Session
"Domestic Violence: An Overview"

10:15 a.m. — Breakout Sessions
"Spouse Abuse"
"Child Abuse"
"Abuse of the Elderly"

11:20 a.m. — Morning Session Overview

12:00 noon — Luncheon - $14.50

1:00 p.m. — Plenary Session
"Adolescent Violence in Nebraska: The Physician's Role"
"Adolescents at Risk: What Do We Say To Them?"

2:10 & 3:10 p.m. — Breakout Sessions
"Substance Usage In Adolescents"
"Depression In Adolescents"
"Adolescent Sexuality"

4:00 p.m. — Afternoon Session Overview

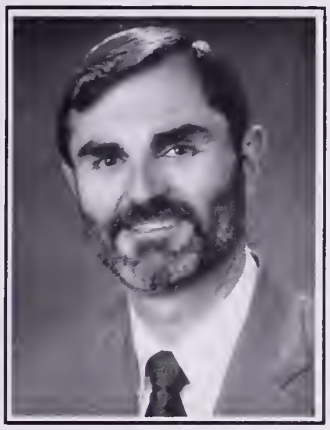
Saturday, April 30, 1994
Marriott Hotel, Omaha, Nebraska

PRESIDENT'S PAGE

Wrapping It Up

ROBERT F. SHAPIRO, M.D.

Each year when the Nebraska Medical Association president is inaugurated he/she (someday) receives, in addition to the usual regalia of office, a plaque which is decorated with a coach, a pumpkin, and the admonition to "Remember It's only a Pumpkin." This plaque is kept for the year and passes to the next president. Its purpose, serving as a reminder that the office is more important than the officer, is to instill proper humility; one year and it's over.



Robert F. Shapiro, M.D.

Alas, this is my last President's Page. It has been an interesting, challenging, and sometimes vexing year. The people you work with and the issues you encounter, however, make it truly a once in a lifetime experience.

The responsibilities and corresponding time commitments associated with the NMA presidency have increased over the years fueled by the many changes in our medical and political environment. One could never begin to keep them sorted out, much less keep up with them without the tireless assistance of Bill Schellpeper, our dedicated executive director, who essentially serves as the president's chief of staff.

Great help and support from the rest of the staff is increasingly important. It has been gratifying to watch Jim Ruigh, our assistant executive director, continue to master his job, assuming new responsibilities on behalf of the medical association. Kelly Madcharo, recently designated as an administrative assistant, has demonstrated remarkable organizational skills. Bobbie Mayrose has edited lengthy tapes from our perhaps too many meetings into minutes, which made us seem smarter and more articulate than we were. Kris Lawton and Janet Swanson complete our multi-talented team of dedicated workers. My heartfelt thanks to them all.

My thanks to the Board of Directors, our Speaker, Vice-speaker, and House of Delegates, which has deliberated long and well to formulate sound policies, which attempt to balance the thoughts, feelings, and preferences of our diverse and independent-minded constituency of Nebraska physicians.

Commission and committee chairholders and members, who perform the detail work of our organization, have been diligent and have generated a number of good ideas.

Our AMA delegation headed by Dr. Roffman has done an outstanding job of representing us. A special note of thanks goes to Dr. Carl Cornelius, who is stepping down after many years of service to the Nebraska delegation and the North Central Medical Conference, a coalition of midwestern states to which we belong.

Chuck Pallesen, David Buntain, and Mary Campbell, our lobbyists, have worked their hearts out for us and have truly done great jobs in difficult and sometimes exasperating times. They have had to work in the State Capitol and in the hearing rooms of the health department to advocate our views, vying with single-minded constituencies who had focused agendas and non-compromising positions.

I want to thank my wife, Dottie, for her forbearance; she allowed me to assume what has amounted to another half-time job; and to

thank my associates, who, when the need was there, were helpful.

The NMA's soon-to-be-installed president, Dr. Fred Paustian, is a person whom I have admired and respected since I was a medical student. He has been marvelous to work with this past year and was a great source of understanding, wisdom, and considerable political savvy. The association will be in good hands.

When all is said and done, however, the most important factor in the equation is YOU, the supporting member. You provide the resources which enable the association to carry out its agenda of activities for you and your patients. To continue to serve as advocates for our patients, and to be able to practice medicine in a desirable and appropriate environment in the future will necessitate even more activity and more effort on all of our parts.

Elaborating further on membership participation, it has been gratifying to see many of our younger colleagues stepping up to express an interest in and even a demand for a significant voice in the decision making process. (Even more of these people would be better.) This is as it should be, since they will have the longest time to practice living with the consequences. Still, the wisdom and experience of more senior physicians are also required. We must continue to contribute and not walk away from future challenges.

During my year as president, one major goal was to focus on access to medical care. To that end, much time, work and effort was directed towards insuring that all physicians and hospitals would be able to participate in the Medicaid Managed Care Program; and not have access restricted to a "narrow network of providers", which might be offered by commercial HMOs. Dr. Caudill, our secretary-treasurer, deserves special commendation for his efforts in this area.

To foster a climate which promoted and permitted patient choice in selecting a physician, we sponsored "willing provider" legislation. L.B. 1341, The "Patient Freedom of Choice Act" would have assured doctors and hospitals a fair opportunity to participate in PPO plans. This bill would have meant many patients would not have to switch from their current physicians in order to receive care. Unfortunately, at least for now, the "choice" argument did not prevail over the "economic" arguments.

The rest of this last President's Page will focus on our Nebraska Department of Health and its capability to serve as a resource to inform us about our use of the potential effectiveness of preventive medicine in Nebraska. This information can be of value to us in clinical practice.

A few weeks ago, I was visiting with Dr. Mark Horton, our director of health. We were discussing potential impacts of measures to prevent or detect disease at an early stage. Our conversation led me to use a portion of the April President's Page to briefly introduce the topics with the May issue of the Journal featuring a detailed guest editorial by Doctor Horton, and a scientific article by Bryan Rettig and Norman Nelson from the Nebraska Department of Health in collaboration with Robert Faulk, M.D. from Medical Imaging P.C. The editorial and article will discuss and review Nebraska's experience with mammography as a means to detect early carcinoma in the over 50 female population. We thank Dr. Ben Gelber, our editor, for his cooperation.

Years ago (1962) as a second year medical student, I perceived public health with its emphasis on preventive medicine and clinical medicine to be different worlds. Karl Potthoff, our professor of public health, taught me to appreciate the value of preventive medicine in its own context, but I never really grasped the two disciplines as a continuum useful in clinical medicine.

Today, that has changed. We live in a world of "managed care". Efficient and effective resource utilization is key to providing proper care in a time of contracting economic resources. Like a Fram oil filter, we can pay now at relatively small cost or pay later at great cost.

Information from the field of preventive medicine has become an important resource we can and should incorporate into our practices to help do our jobs better, more efficiently, and less expensively.

Dr. Horton's editorial and Bryan Rettig's article exemplify how techniques employed by specialists in public health can be used to gather information to evaluate our performance with a particular procedure and make judgements about what is being done and what we can do better.

For example, when a procedure like mammography becomes generally accepted as desirable and available, then the gold standard

would be to have 100% of the people who will be benefited by the study examined. As will be indicated in the article next month, the American Cancer Society and the National Cancer Institute, both recommend that women over 50 years of age have screening mammography as well as a clinical breast exam annually. Achieving this target may not always be attainable; however, it should be our goal. (There is still controversy about the value of mammography in women under age 50, and this category was not evaluated.)

The Nebraska Behavioral Risk Factor Surveys study cited in the article restricts evaluation to women over 50. From the survey it appears that Nebraska data is improving; however, as you will see, we are still doing poorly compared to the rest of the nation. The article also discusses reasons why this might be.

If we use this information to change our practice, we make a positive contribution to our patients' health. We must make that effort.

Another important consideration is the observation that in a small but significant number of cases, abnormal findings (not Nebraska experience) were not followed up. It is noted that with a computerized data base generating a follow-up letter that follow-up was significantly better. In addition to promoting mammography, we will want to have in place procedures to assure optimum follow-up.

To supplement efforts we direct towards procedures over which we have control; mammograms, pap smears, PSAs, and lipid screens, we can take the opportunity to educate people about significant lifestyle changes, which have the potential to add meaningful healthy years to their lives. These efforts would reflect the interrelationship between pubic health and clinical medicine.

My year of President's Pages is at an end. It has been a pleasure to serve you as your president.

GUEST EDITORIAL

Trading Places: The Associated Press Football and US News and World Report Medical School Polls

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Among the many things that will denote the year 1993, will be a flurry of interest in polls and surveys. In football, for example, what ordinarily is a very straight forward process of ranking America's top collegiate teams became a controversial issue. By December, the Associated Press Poll ranked a team with one defeat ahead of three other teams with no defeats. Much politicking occurred over the issue of which team was really better, with the actual team records becoming obscured in the process.

Of interest was the fact that the Associated Press pollsters were always identified. These men and women were sportswriters who followed football closely. Because of their particular expertise, their opinions as to who was #1, #2, etc., were highly valued.

Of further interest was the fact that these votes were made public. Consequently, fans knew which reporters ranked undefeated Nebraska first, and in one instance, which reporter ranked Nebraska eighth. Each reporter felt very strongly that his/her position was correct, and reflected the fairest rankings of the college teams. However, many different sports journalists seemed to have different reasons for ranking teams in the manner they chose.

I thought of all this the other day when I received a letter and ballot from *US News and World Report* asking me to vote on the top twenty medical schools in America. Apparently, university-based residency directors have received these sorts of ballots for several years. However, having spent the last several years in a community-based family practice program and only the past six months with a residency which was medical school-based, this sort of voting was new to me.

Most of us are familiar with the *US News and World Report* list of "bests". The magazine annually publishes its list of the top ten colleges, law schools, medical schools, etc. I had always thought this process was interesting, but had never imagined that I would have an opportunity to cast a vote. Consequently, I read the ballot and instructions carefully.

In reviewing the instructions, I found that *US News and World Report* had arbitrarily divided American medical schools into two groups. One group represented the 60 medical schools which annually receive the most research funding. The other grouping was for institutions whose primary mission, in the opinion of *US News and World Report*, was to produce primary care physicians. Physicians were sent a ballot which included one or the other of these two groups, but not both.

At the outset, this sort of arbitrary segregation left me more than a little miffed. Was *US News and World Report* trying to imply that a medical school could not be a recipient of large grants and still produce primary care physicians? Or perhaps, in order to produce primary care physicians, the institution is supposed to turn its back on research. Either way, I was uncomfortable with this sort of categorization.

It didn't help that I had obviously been chosen to receive a ballot for the research-oriented schools. My ballot contained some of the most prestigious institutions in the country, but did not include either Creighton University or the University of Nebraska. For that matter, neither my alma mater, the University of Missouri, nor the two medical schools in West Virginia at which I had formerly held clinical appointments, were included either.

In spite of this, I picked up the ballot and prepared to mark it. I read the instructions again. I was to mark, from this list, the 20 schools that produced the best physicians.

The best physicians. That's what the ballot said. Not the best researchers. Not the best academicians. Not the best article droppers and journal quotes. But the best physicians.

I looked out the window and shook my head. Does *US News and World Report* really know what they're asking me, I thought? Just a few days earlier I had read an article by Dr. Robert

Petersdort,[1] President of the American Association of Medical Colleges, documenting the dismal performance of those medical schools that did not have departments of family practice in producing primary care physicians. Petersdorf's data showed that medical schools without family practice departments not only produced virtually no family physicians, they produced virtually no general pediatricians or general internists, either. Even when the definition of primary care was stretched "to the max", these schools still had a pathetic track record for producing "generalists".

I took a deep breath, and began to mark my ballot. "If best physicians is what you want, *US News and World Report,"* I thought, "then the schools that produce the best physicians (in my opinion) will be what you get." But if by 1993 an American medical school does not have within its structure a department of family practice, much less other family practice experiences and role models to its students, how can it be viewed as an institution that can produce quality physicians? If I was to vote for the schools that produced the best physicians, I obviously could not vote for those schools that had no department of family practice — regardless of that school's prestige, grant funding, or research reputation.

I smiled at the thought of those schools, all of which having no department of family practice, would not be marked on my ballot, Forget it Harvard. Take a hike Yale. Sorry about that Johns Hopkins. Washington University in St. Louis? Take your Manual of Medical Therapeutics and shove it. You won't get my vote. University of Chicago, your list of Nobel prize winners is impressive. But with no department of family practice, your academic and intellectual foundation is incomplete.

Stanford and Northwestern? Both have relegated family practice to the second class citizen status of a "division" or a "section". This tells me that you may understand that family practice is important, but don't recognize it as being as important as other specialties. Your names won't be circled on my ballot. But what's this? Emory University now has a department of family practice! For years this Atlanta-based institution was a bastion of anti-family practice sentiment. Recently family practice has gone from being persona non grata to a full fledged department. Only time will tell if this is a true educational conversion, or a marketing ploy. If the former is true, they may get my vote next year.

What, then, was left to mark? Actually, some very fine schools on this research-oriented list had a track record of supporting family practice.

In addition to being a world renowned medical facility, the Mayo Medical School has been a strong supporter of family practice for years. Dartmouth University, with its Main-affiliated residency programs, also stood out on the list.

The University of Washington, the University of Iowa, the University of Michigan, Case Western Reserve, the University of Texas-Southwestern, and the University of Virginia all with strong family practice departments, received my vote.

And finally, there was Duke University. This was the medical school with a long standing department of family practice, who, just a few years ago, decided that family practice was not a part of the "mission" of the university. Duke announced that it would close its department of family practice. Immediately, several hundred practicing family physicians in North Carolina contacted Duke to wish the institution well, and inform it that all tertiary referrals would now be going to other institutions. Almost as quickly, Duke announced that all of this talk about dropping family practice had been a misunderstanding, and the department would stay. With a chuckle, I gave Duke my vote. Any academic medical center that displays such a high degree of common sense deserves recognition.

As I mailed my ballot, I wondered if my own ranking of medical schools would cause any sort of stir among the vote counters. Would someone pick up my ballot and wonder who was this crazy guy from Omaha who refused to vote for some of America's prestigious institutions? Or would my ballot be computer scored, and reveal itself as only a meaningless blip on a computer-generated display of votes?

If the latter is true, I will at least have the satisfaction of knowing that I honestly voted for those schools listed on my ballot that I believed produced the best quality physicians.

However, if the former is true, like the sportswriter who chose to rank Nebraska eighth, it might just rattle someone at *US News and World Report* enough to want to contact me for an explanation. If this is the case, they know where they can reach me.

I would be glad to give them an earful.

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ORIGINAL ARTICLE

Historical Perspective of Rh Disease in Nebraska (1973-1982) Part II. Profile of Rh Negative Women Experiencing A Fetal Death

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INTRODUCTION

TRANSPLACENTAL hemorrhage has been implicated as the cause of sensitization of Rh negative women with an Rh positive fetus.[1] This most often occurred at the time of delivery. Evidence exists that sensitization can occur throughout pregnancy.[2] For Rh negative women experiencing a fetal death, the possibility of sensitization to the Rh antigen and a subsequent infant with Hemolytic Disease of the Newborn (Rh HDN) can become a reality. A greater threat exists when a spontaneous abortion is followed by a dilatation and curettage. To eradicate Rh HDN, it is necessary to identify and administer Rh_0 (D) Immune Globulin (Rh IG) to unsensitized Rh negative women whose fetus or husband is Rh positive or of unknown Rh type experiencing a fetal death. The data were collected to compliment a previous study of Rh negative women delivering live newborns from January 1, 1973 through December 31, 1982.[3] Periodic future surveys will be helpful in determining areas of omissions of Rh IG. The data were collected during the period when only postpartum IG was administered.

METHODS AND MATERIALS

In Nebraska, regulations require that a fetal death of twenty (20) or more weeks be reported to the Nebraska State Health Department.[4] An inquiry was sent to each hospital's record room administrator by the Division of Maternal and Child Health to identify the Rh types of both the mother and fetus, and whether Rh IG had been administered. A member of the Maternal and Child Health staff personally reviewed the hospital records when the responses noted the Rh types of the women and/or fetus were unknown, or the Rh IG was omitted when indicated. The hospital records of all women sensitized to the Rh antigen were also reviewed by a staff member. Low response rates and difficulties in the logistics of verification of responses to fetal deaths occurring at home (Table 1) introduced biases which were not thought to be significant to include.

This retrospective survey was initiated approximately three years after the prospective survey of the utilization rates for Rh IG for a live birth. The review of the hospital records frequently occurred three to five years after the hospitalization for the fetal death.

RESULTS

From January 1, 1973 through December 31, 1983 there were 2,347 fetal death certificates (Table 1) filed with the Bureau of Vital Statistics of the Nebraska State Health Department.[5] For the ten years, fetal deaths of twenty or more weeks of gestation numbered approximately 0.91% of live hospital births in Nebraska. The number ranged from a low of one hundred ninety-five (195) in 1976, to a high of two hundred fifty-six (256) in 1974, with an average of two hundred thirty-five (235).

Data relevant to 2,265 hospitalized women experiencing a fetal death of twenty (20) or more weeks were analyzed (Table 1 and Table 2).

The percent of documented Rh negative and unknown Rh types averaged 16.2% for the ten years. The expected theoretical percentage in the general population is 15%.[3] For the entire study period 22 women (0.97%) were not Rh typed. During the first five years fourteen (14) women did not have a recorded Rh type. This was reduced to eight (8) in the second five years. In only one year (1980) were the Rh types of all women determined.

When a multiple gestation pregnancy occurred, only one fetal Rh type was recorded. If one or more fetuses were more positive, only one was counted as positive; likewise, if one or more fetuses were negative, only one was recorded as negative. This procedure was used, as the prime concern of the study at that time was to determine the utilization of Rh IG. Table 3 reveals the Rh types of the fetuses delivered

by women who were Rh negative and of an unknown Rh type.

The percent of fetuses who were Rh positive plus fetuses whose Rh type was unknown was 86.7%. This is greater than the expected theoretical percentage; in the general population, a pregnant Rh negative woman having an Rh positive fetus is 65%.[3] For the entire ten years, forty-three (43) or 1.9% of the fetuses (using a single count for a multiple gestation) did not have a recorded Rh type. There were twenty-five (25) fetuses whose Rh type was unknown in the first five years, compared to eighteen (18) without a documented Rh type in the second five years. With one exception, all mothers whose Rh type was unknown had a fetus whose Rh type was not recorded.

TABLE 1

Fetal deaths, twenty (20) or more weeks, reported to the Nebraska State Health Department. Number of fetuses excluded from survey. Number of women included in survey, 1973 through 1982.

YEAR	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Total Number of Fetal Death Certificates Submitted to Nebraska State Health Department	250	256	233	195	216	231	242	248	234	242
Fetuses Delivered At Home	4	2	3	6	3	4	4	2	2	0
Missing Hospital Records	6	3	0	0	0	0	2	1	0	0
Excess Number of Fetuses (Multiple Gestations)	2	4	3	2	5	5	3	8	4	4
Number of Women Experiencing A Fetal Death Included in Survey*	238	247	227	187	208	222	233	237	228	238

*Multiple Gestations Counted Once

TABLE 2

Number of women experiencing a fetal death in Nebraska hospitals; Rh status of women, 1973 through 1982.

YEAR	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Number of Women Experiencing A Fetal Death	238	247	227	187	208	222	233	237	228	238
Rh Status of Women										
Negative	34	36	40	33	21	36	36	39	37	32
Unknown	4	6	1	2	1	1	2	0	3	2
Percent of Rh Negative and unknown Rh Type Women	16%	17%	18.1%	18.7%	10.6%	16.7%	16.3%	16.5%	17.5%	14.3%

TABLE 3

Rh Status of fetuses delivered from Rh negative and unknown Rh type women. Nebraska hospitals, 1973 through 1982.

YEAR	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Rh Status of Fetuses Delivered by Rh Negative Women and Women of unknown Rh Type										
Positive	29	26	34	28	19	30	25	30	31	22
Unknown	7	10	4	3	1	2	7	1	4	4
Negative	2	6	3	4	2	5	6	8	5	8
Percent of Rh Positive and unknown Rh Fetuses Delivered by Rh Negative and women of unknown Rh Type	94.7%	85.7%	92.7%	88.6%	90.9%	86.5%	84.2%	79.5%	87.5%	76.5%

Table 4 shows the number and percent of women experiencing a fetal death of 20 or more weeks sensitized to the Rh antigen as documented on the hospital chart.

During the first five years twenty-seven (27) were sensitized. The number was reduced to ten (10) during the second five years.

Utilization ratios of Rh IG were calculated by dividing the number of postpartum women receiving the Rh IG by the number of women eligible for Rh IG. The cardinal requirement of administration to an unsensitized Rh negative woman with an Rh positive fetus was followed. Additional candidates, considered to be at risk of sensitization, included women whose Rh type was unknown and who had a fetus whose Rh type was either positive or unknown. The utilization percentages and number of omissions are summarized in Table 5. Forty-one (41) postpartum women for the entire period did not receive Rh IG. Twenty-two (22) of these omissions occurred in women whose Rh type was not recorded.

The hospital records revealed only three women refused the Rh IG (one each in 1974, 1975 and 1982). Refusals were not counted as an omission. Two of the women had postpartum sterilizations and in one family the father was to have a vasectomy.

DISCUSSION

If Rh Hemolytic Disease of the Newborn is to be eradicated, Rh negative women in the reproductive cycle experiencing an unscheduled event such as a fetal death need protection with Rh IG. Rh positive red cells enter the maternal circulation via tiny breaks in the integrity of the Chorionic Villus. Fetal erythrocytes have been found in varying numbers in the maternal circu-
fetuses who did not have a recorded Rh type. Omissions were more apt to occur in an obstetrical center (number = 25), which usually had more than 300 deliveries a year, than at a community level hospital (number = 16). From the fetal death certificates, it was determined that twenty-two (22) of the forty-one (41) women who did not receive the Rh IG had no living children at the time of the study.

As part of a series on events leading to Rh isoimmunization in Nebraska women, the number of Rh negative women at risk of being sensitized in any one year can be influenced by a number of "environmental factors". Fertility rates, the number of previous pregnancies, live birth order, desired number of children, and a pregnancy prior to the introduction of Rh IG can alter the trend in the number of women sensitized. During the first five years 1,107 women had experienced a fetal death and twenty-seven (27) women were sensitized (mean 5.4, S.E.M. $\pm$ 1.0, $p < 0.05$); during the second five years 1,158 women had experienced a fetal death and ten (10) (mean 2.0, S.E.M. $\pm$ 0.3, $p < 0.05$) were sensitized. Because of the large number of variables present, it is not possible to attribute this statistically significant improvement to the utilization of Rh IG. During the first five years 2.36% of the cohort was sensitized; during the second five years 0.86%

TABLE 4

Number and percent of women experiencing a fetal death who were sensitized to the Rh Antigen. Nebraska hospitals, 1973 throuth 1982. Mean, $\pm$ S.E.M. and p - value < 0.05 in text.

YEAR	1973	1974	1975	1976	1977	Total
Number of Women Experiencing A Fetal Death Who Were Sensitized to Rh Antigen	8	7	6	3	3	27
Percent of Women Experiencing A Fetal Death Who Were Sensitized to Rh Antigen	3.4%	2.8%	2.6%	1.6%	1.4%	

YEAR	1978	1979	1980	1981	1982	Total
Number of Women Experiencing A Fetal DeathWho Were Sensitized to Rh Antigen	3	2	2	1	2	10
Percent of Women Experiencing A Fetal Death Who Were Sensitized to Rh Antigen	1.4%	0.86%	0.84%	0.44%	0.84%	

were sensitized. In 1973, 3.4% of the study cohort were sensitized; this was reduced to 0.84% in 1982. An analysis of the women sensitized will be presented in a future publication.

An overall utilization ratio of 83.8% of the Rh Immune Gloublin would indicate that the practicing physician is aware of the value of Rh IG in the prevention of Rh Hemolytic Disease of the Newborn. During the first five years 82.3% (mean 4.6, S.E.M. $\pm$ 5.2, p. < 0.05) of the eligible women received the Rh IG. During the second lation as early as the 10th or 11th week of gestation.[6] The Rh antigen has been demonstrated in the fetus as early as the 38th day of gestation and there is evidence of blood circulation by 4 weeks. The risk of Rh isoimmunization increases with the gestational age. At one month it's virtually negligible, approximately 2% of two months and 9% at three months and beyond. Gaps in the utilization of preventive measure (Rh IG) for women with fetal wastage may be substantial.

The data were collected for a ten year period from an obstetrical population receiving care in a defined geographical location. Educational programs for the use of the Rh IG were started in 1968. The time interval to identify the risk population (women experiencing a fetal death of 20 or more weeks) and the collection of the data varied between three and five years.

The results obtained are a reflection of the data missing in the hospital records. The number of women who were designated as being at risk of sensitization to the Rh antigen is probably inflated by the missing data (Rh types) which appears to be dependent on whether prenatal care was obtained. For the entire cohort during the ten years, four (4) women definitely had no prenatal care and another nine (9) were suspect of no prenatal care, from information provided by the hospital record and birth certificate. It was noted, if the mother did not have a recorded Rh type (number = 22) likewise her fetus (number = 21) did not have a documented Rh type. During the first five years fourteen (14) women did not have a recorded Rh type. This was reduced to eight (8) during the second five years. Of these eight, two (2) definitely had no prenatal care and six (6) are suspect of none. In Nebraska during the same timeframe, 95% of the mothers with a live birth and prenatal care in the first (78%) or second trimester. Overall, forty-three (43) fetuses did not have a recorded Rh type; twenty-five (25) during the first five years eighteen (18) during the second five years. The mothers of seven of the fetuses with an unknown Rh type had a postpartum sterilization without the administration of Rh IG.

The percent of eligible women (at risk of Rh sensitization) who received the Rh IG is noted in Table 5. For the ten years the average utilization was 83.8% in contrast to the average utilization for postpartum women after a live birth of 95% (99.5% in 1982).[3] As previously reported, the number of omissions (Table 5) was related to the number of women and fetuses who did not have a recorded Rh type. five years 85.3% (mean 3.6%, S.E.M. $\pm$ 3.7 p. < 0.05) of the eligible women received the Rh IG. There was no statistical increase noted for the second five year period. Lack of prenatal care and education of Rh disease may have influenced some women to leave the hospital early, prior to receiving the Rh IG. It is possible that some eligible postpartum women received the Rh IG at their physician's office. Whereas, the study on the utilization of Rh IG, for women with a live newborn, was prospective in nature, with an Rh log as a reminder for hospital personnel. This study was retrospective.

CONCLUSION

An unscheduled event, such as woman experiencing a fetal death of twenty (20) or more

TABLE 5

Percent of eligible women experiencing a fetal death and eligible to receive RH IG. Numer of Omissions. S.E.M. and P in text. Mean, I S.E.M. and p - value < 0.95 in text

YEAR	1973	1974	1975	1976	1977
Percent received Rh IG	75%	65.5%	87.5%	89.3%	94.1%
Number of Omissions Rh IG	7	9	3	3	1

YEAR	1978	1979	1980	1981	1982
Percent received Rh IG	90%	71.9%	93.3%	88.2%	83.3%
Number of Omissions Rh IG	2	7	2	4	3

weeks, resulted in only an 83.8% utilization of Rh Immune Globin between January 1, 1973 and December 31, 1983.

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The results are expressed as mean ± S.E.M. Data were analyzed using Mann-Whitney u-test. A p-value of < 0.05 was considered to be statistically significant.

ORIGINAL ARTICLE

Isolated Systolic Hypertension: A Different Kind Of High Blood Pressure

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INTRODUCTION

IN the recent past there have been several studies[1,2] directed at isolated systolic hypertension and its treatment. In this review, an attempt will be made to answer pertinent questions regarding this entity. The complications of isolated systolic hypertension and those patients at greatest risk will be delineated with special emphasis on treatment options and strategies.

MECHANICS OF ISOLATED SYSTOLIC HYPERTENSION

Isolated systolic hypertension, by definition, is a systolic blood pressure equal to or greater than 160 mm/Hg and a diastolic blood pressure equal to or less than 90 mm/Hg. It is well established that this is primarily a disease of the elderly, and the risk factors for the development of isolated systolic hypertension are increasing age, sex (with women having a higher prevalence than men), and obesity (specifically, in women).[3] Understanding the mechanism of isolated systolic hypertension involves a knowledge of the determinants of the systolic arterial pressure. Cardiac output, stroke volume, left ventricular ejection velocity, total peripheral resistance, and arterial distensibility or compliance are the components of systolic arterial pressure. It is known that cardiac output[4], stroke volume[5], and left ventricular ejection velocity[5] do not increase with age. Cardiac output commonly decreases with age.[4] It is well established that increased total peripheral resistance results in an increase in systolic blood pressure, diastolic blood pressure, and mean arterial pressure and is not a cause for isolated systolic hypertension[6]. Studies have also shown that increased total peripheral resistance is seen in normotensive elderly patients[5] and this is most likely a phenomenon of aging and not necessarily a causative mechanism for isolated systolic hypertension. The mechanism is felt to be decreased arterial compliance, with a resultant increase in systolic blood pressure and a decrease in diastolic blood pressure.[6]

COMPLICATIONS OF ISOLATED SYSTOLIC HYPERTENSION

The dangers of isolated systolic hypertension need to be addressed so a decision can be made concerning the potential benefits of treatment. In the Framingham Study in 1981[7], isolated systolic hypertension was found to predispose to stroke independent of arterial rigidity. Patients with isolated systolic hypertension had 2-4 times as many strokes as normotensive patients and their diastolic blood pressure added little or nothing to this stroke risk assessment. The recently published Systolic Hypertension in the Elderly Program (SHEP) trial[2] revealed a 54% decrease in left ventricular failure, a 36% decrease in stroke, and a 25% decrease in coronary artery disease in treated subjects. Cardiovascular mortality was 20% lower in the treated vs. placebo groups. In the Medical Research Council (MRC) trial[1] treatment with a diuretic reduced the risk of stroke 31%, coronary events 44% and all cardiovascular events 35%, when compared to placebo. These studies served to delineate the importance of drug therapy as opposed to placebo (or no treatment) in preventing the morbidity and mortality associated with isolated systolic hypertension.

TREATMENT OF ISOLATED SYSTOLIC HYPERTENSION

Once a decision has been made to treat, several options are open to the clinician. Important considerations include the recognition that we are working with an elderly population and that treatment should be individually tailored to meet their needs and that side effects, cost, and problems with postural hypotension always need to be kept in mind. Recommendations should include weight loss, sodium restriction, exercise,

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limiting of alcohol, and avoidance of drugs known to precipitate hypertension. If drug therapy needs to be used, one should always start with low doses, use a standing blood pressure to assess adequate treatment, and have a target systolic blood pressure goal of 160 mg/Hg or less. Standing blood pressure is preferable, especially in the elderly[8], since aggressive treatment of supine blood pressure often leads to orthostatic symptoms with minimal activity. Orthostatic symptoms or cerebral ischemia at a specific blood pressure can aid the clinician in establishing a target blood pressure. When reviewing the studies[1,2] it appears that treating with medication patients in a high-risk category could be the wisest use of resources. Those with high risk can be defined as smokers, those with known coronary artery disease, those with previous cerebral vascular accidents, and those with known complications of hypertension, i.e. renal insufficiency and aortic aneurysms.

Low dose diuretic therapy, i.e. hydrochlorothiazide 12.5 mg to 25 mg, appears to be the drug of choice. Chlorthalidone was the diuretic used in the SHEP trial[2] that had the most convincing results. With such low dose diuretics, the V.A. Cooperative Study[9] documented that the serum potassium level is not reduced as significantly as occurs with the higher dose, but that the reduction in blood pressure is similar between the lower and the higher dose of diuretics. Most importantly, the decrease in morbidity and mortality associated with isolated systolic hypertension has been best documented with diuretic treatment. In SHEP[2], beta blockers offered some decrease in morbidity and mortality but in the Medical Research Council trial[1] they provided neither. Though the side effect and effectiveness profile of calcium channel blockers and ACE inhibitors are comparable, studies addressing their effect on morbidity and mortality in isolated systolic hypertension have not been done.

SUMMARY

Isolated systolic hypertension is a distinct disease entity associated with serious morbidity and mortality, in particular, stroke. The mechanism of systolic hypertension appears to be a reduction in arterial compliance. Identification of patients at greatest risk is paramount. A simple nonpharmacologic or pharmacologic intervention can decrease isolated systolic hypertension, enhance quality of life and prevent major cardiovascular and cerebrovascular complications.

REFERENCES

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ASK A LAWYER

1. When is it appropriate to use restraints on an unsafe patient?

Federal regulations on the use of restraints reflect a significant change in the way health care providers are starting to view the use of such devices. Medical literature has indicated that routine employment of restraints is not effective legal risk management. In fact, commentators have predicted that litigation associated with injuries from the use of restraints will be even more substantial in frequency and severity than litigation associated with the non-use of restraints.

As a result, the federal regulations embodied in OBRA of 1987 may provide useful guidance as they require that restraints may not be used for discipline or convenience, but may only be used when required to treat the patient's medical symptoms. According to the statute, prior to the use of restraints, there must be a consultation with appropriate health professionals, such as physical therapists, regarding less restrictive alternatives. If less restrictive alternatives are inappropriate, the use of the restraining device must first be explained to the patient, a family member, or a legal representative who agrees to this alternative treatment employed only for a specific period of time. If medical symptoms are life threatening (such as dehydration or electrolyte imbalance) a restraint may be used to provide necessary life-saving treatment.

2. What should be included in our facility's written policy on the use of restraints?

Both federal regulations embodied in OBRA of 1987 and state guidelines for the State of Nebraska require medical facilities to develop and implement a clear written policy on the use of restraints. The State of Nebraska Department of Health Regulations, Title 175, Chapters 8 and 12: Regulations and Standards for Intermediate Care Facilities and Skilled Nursing Facilities state that such policies must clearly delineate at least the following:

1. An order must indicate the specific reasons for use of restraints, and type of restraint to be used.
2. The use of restraints shall be temporary and the resident will not be restrained for an indefinite amount of time.
3. A resident placed in the restraint shall be checked at least every thirty (30) minutes by appropriately trained staff and an account must be kept of this surveillance.
4. Reorders are issued only after a review of the resident's condition.
5. The use of a restraint shall never be employed as punishment, for the convenience of staff, or as a substitute for supervision.
6. Mechanical restraints must avoid physical injury to the resident and provide a minimum of discomfort.
7. The opportunity for motion and exercise must be provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed, except at night.
8. The practice of locking residents in their rooms or the use of locked restraints also constitutes physical restraint, and, when utilized, must be in compliance with the requirements of the Regulations promulgated by the State Fire Marshal, as well as meet the requirements contained in this standard.

***

"Ask a Lawyer' is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen with the assistance of UNL College of Law student Jane Kemper of the Cline Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

ALLIANCE

BARBARA BOHI
NMAA President

The NMAA has spent the year trying some new things but still struggling with some problems that seem to plague us year after year.

This year we combined our mid-winter meeting with Legislative Day in the hope of attracting more participants. Some business needs to occur mid-winter, so it seems necessary to include something between September and April, on our calendar. Our joint effort in the April Walk/Run for the benefit of Make-A-Wish Foundation seemed like a reason for the different county alliances/auxiliaries to feel some connection. I hope they did.

As a state alliance, we have encouraged the NMA and our members to do what they can to educate people about domestic violence. We helped sponsor Marilyn Van Derbur when she spoke in Lincoln last fall at the "There's No Excuse For Domestic Abuse" kick-off campaign. Carmen Kleager, NMAA Vice-President has contacted District Councilors in the hope that they will distribute in their communities AMAA brochures on family violence. We are very pleased that the NMA has chosen to address the issue of domestic violence at its Scientific Sessions, April 30th.

At this point, membership is less than hoped for but steadily moving upward. Our total on March 31 will "tell the tale." Motivating and enlisting NMAA members to attend meetings, do their committee assignments, and promote the group are never-ending challenges. The NMA appears to be a strong organization. I see us as physicians' spouses endorsing its efforts in support of our spouses and the health of patients in Nebraska.

My theme this year has been "Partners In Medicine's Future." I know that's how I feel. Do you?

WELCOME NEW MEMBERS

Patrick J. McGrath, M.D.
220 West Leota
North Platte, NE 69101

George W. Bartholow, M.D.
1700 N. Victory Rd.
Norfolk, NE 68701-1209

Jeffrey D. Matthes, M.D.
1600 S. 48th St.
Lincoln, NE 68506

Ameeta B. Martin, M.D.
St. Elizabeth CHC
555 S. 70th St.
Lincoln, NE 68510

Laurel L. Crusinberry, M.D.
2221 S. 17th St., #102
Lincoln, NE 68502

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Lincoln, NE 68510

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4740 A Street
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Jeffrey T. Marple, M.D.
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Lincoln, NE 68502

Steven L. Martin, M.D.
1919 S. 40th St., #300
Lincoln, NE 68506

Rafael Tatay, M.D.
2221 S. 17th St., #203
Lincoln, NE 68502

Douglas P. Tewes, M.D.
1000 S. 13th St., P.O. Box 2636
Lincoln, NE 68502

Jennifer H. Cyr, M.D.
11920 Burt St., #170
Omaha, NE 68154

Lawrence Fitzgerald, M.D. (reinstated)
12713 S. 28th Ave.
Omaha, NE 68123

Andrew C. Friedman, M.D.
UNMC - 600 S. 42nd St.
Omaha, NE 68198-3280

Stacey L. Hennesy, M.D.
OB/GYN Health Center
10101 Maple St.
Omaha, NE 68134

Kristen Engdahl Hoffman, M.D.
720 N. 87th St., #100
Omaha, NE 68114

Frederick A. McCurdy, M.D.
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Omaha, NE 68198-2165

James R. Neff, M.D.
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Jeffrey S. Nelson, M.D.
8552 Cass St.
Omaha, NE 68114

Robert S. Kohlbacher, M.D.
Our Lady of Lourdes Hospital
1500 Koenigstein
Norfolk, NE 68701

COMING MEETINGS

CREIGHTON UNIVERSITY

APRIL 22-23, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

MAY 2, 1994 — Abruptio Placenta - OB Outreach Program at Offutt Air Base, Omaha, NE.

MAY 19-22, 1994 — A Review of Orthopaedics and Orthopaedic Pathology - Criss II Building, Creighton University, Omaha, NE.

MAY 27-29, 1994 — Family Medicine Update, Okoboji, IA.

JUNE 6, 1994 — Medical Therapy of the Fetus - OB Outreach Program at Offutt Air Base, Omaha, NE.

JUNE 29, 1994 — Couple to Couple League - "Natural Family Planning: The Time Has Come" - St. Joseph Hospital, Omaha, NE.

JULY 27-28, 1994 — Current Concepts in Subacute Care - Marriott Hotel, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

AUGUST 12-13, 1994 — Advanced Laparoscopy for Gynecologists - St. Joseph Hospital and Creighton University Campus, Omaha, NE.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 2500 California Street, Omaha, NE 68178.

MAYO FOUNDATION

SEPTEMBER 12-14, 1994 — The Norwegian-American Orthopaedic Society, Program site: Rochester, MN.

SEPTEMBER 23-24, 1994 — The Lower Extremity Amputee: A Multidisciplinary Approach, Mayo Foundation, Rochester, Minnesota, Registration fee: $300, 15 credit hours in Category I AMA.

OCTOBER 15-16, 1994 — International Symposium on Myeloproliferative Disorders, Program Site: Rochester, MN.

OCTOBER 23-27, 1994 — Advances in Diagnostic Radiology, The Cloister, Sea Island, Georgia. Registration fee: $595, 22.5 credit hours in Category 1 AMA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

METRO OMAHA MEDICAL SOCIETY/ OMAHA MIDWEST CLINCAL SOCIETY

TUESDAY, APRIL 26, 1994 — "How to Collect for Control". Jeff Staads, exclusive instructor on Collections for the Medical-Dental-Hospital Bureaus of America will present a workshop from 9:00 a.m. to 4:00 p.m. at Midlands Community Hospital, Papillion, NE. Cost is $59 for MOMS, OMCS and NMA member offices. $80 for non-member offices.

TUESDAY, MAY 3, 1994 — "Elder Abuse: Out of the Shadows", New Tower Inn, Omaha, NE. Kenneth Chelucci, M.D. speaker. Examine the detection and documentation of elder abuse and the physician's role in maintaining the chain of evidence. 2 credit hours in Category 1 AMA.

SATURDAY, JUNE 18, 1994 — "Family Health Day at Henry Doorly Zoo", Omaha, NE. CME for physicans with added events for families. $120 for CME and family activities. Topics: Asthma, Diabetes, Cholesterol and Hypertension. 7 credit hours in Category 1 AMA and 6.5 credit hours AAFP.

TUESDAY, JUNE 7, & WEDNESDAY, JUNE 8, 1994 — Half day seminars on "The Art of Good Patient Relations" (training for physician's office staffs). Instructor: Janice K. Woerth, Ph.D. Washington D.C.

WEDNESDAY, JUNE 8, 1994 — "Reduced or Denied Claims: How To Prevent Them". Insructor: Janice K. Woerth, Ph.D., Washington D.C.

For further information on any of the above seminars contact the MOMS/OMCS, 7906 Davenport, Omaha, NE 68114, (402) 393-1415.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

THURSDAY - SATURDAY, APRIL 14-16, 1994 — 2nd Annual Diagnostic Dilemmas in Women's Health Care, Marriott Hotel, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Fee: $200.

11 DAYS, APRIL 18-29, 1994 — Family Practice Review, Center for Continuing Education, UNMC, Omaha, NE. Target Audience: Family Physicians, Fee: $1100 - two week session, $750 - one week session, $1250 - split sessions.

THURSDAY-FRIDAY, JUNE 12-15, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Obstetrics and Gynecology, Oncology/Hematology & Researchers.

THURSDAY-SATURDAY, JULY 14-16, 1994 — 1994 National Conference on Family Violence: Research and Practice, Holiday Inn Centre, Omaha, Nebraska. Target Audience: Multidisciplinary (health professionals, sociologists, criminal justice).

TUESDAY-FRIDAY, JULY 19-22, 1994 — Pan Pacific Lymphoma Conference, The Ritz Carlton - Mauna Lani, Kohala Coast, Hawaii. Target Audience: Oncology/Hematology & Researchers.

FRIDAY-SUNDAY, AUGUST 19-21, 1994 — Imaging and Breast Cancer, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians.

MONDAY, SEPTEMBER 26 - SATURDAY, OCTOBER 1, 1994 — Emergency Medicine, 1994, Skills and knowledge for the Practicing Physicians, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

ONGOING CONTINUING MEDICAL EDUCATION PROGRAMS

ADVANCED CARDIAC LIFE SUPPORT — Provider, Renewal and Instructor.

PEDIATRIC ADVANCED LIFE SUPPORT— Provider, Renewal and Instructor.

ADVANCED TRAUMA LIFE SUPPORT — Provider and Reverification.

ADVANCED LIFE SUPPORT IN OBSTETRICS — Provider

These programs are offered by the Center for Continuing Education throughout the year.

For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuting Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

THURSDAY-FRIDAY, APRIL 21-22, 1994 • Symposium On Obstetrics & Gynecology, Location: St. Louis, Missouri.

FRIDAY-SUNDAY, JUNE 24-26, 1994 • Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862.

AMA NEWS NOTES

MEDIA BRIEFING AND CONFERENCE FOCUS ON VIOLENCE AT HOME

"Out of the Darkness: Real Issues in Family Violence" was the title of the AMA March 10 media briefing in Washington, D.C.

The briefing preceded the AMA's three-day National Conference on Family Violence: Health & Justice, an invitational symposium for health and law family violence professionals.

George Gallup, Jr., announced results of the Gallup International Institute's 1994 survey on teen violence and discussed the impact of guns in the home.

The National Conference on Family Violence brought together experts from more than 100 health, justice, social service, education advocacy groups and the media.

The conference was designed to help health professionals better recognize the signs of family violence and develop local programs to reduce violence and improve services.

Conference speakers included Janet Reno, U.S. attorney general; David Satcher, MD, director of the Centers for Disease Control and Prevention; Joycelyn Elders, MD, U.S. surgeon general; and Donna Shalala, PhD, secretary of HHS.

* * *

AMA ALERTS PHYSICIANS TO GET INVOLVED NOW AND MAKE REFORM WORK

The AMA has launched an urgent "get involved now" campaign, calling on physicians to help create a reformed health system patients deserve.

"Right now, Congress is making decisions that will change the shape of the nation's health care system. Decisions that will change the way you practice medicine and the way your patients receive treatment. That's why it is crucial for you to get involved now. This is your call to action."

"Certain key elements must be included in the final plan if we are to enhance competition and preserve the quality of the health care system."

Physician involvement is vital, the AMA said. "Now more than ever we need your support and your voice to get our message across."

AMNews' March 14 cover wrap headline, "Voice + Choice + Coverage = AMA support," spelled out specific reform measures physicians want Congress to enact: coverage for everyone, choice for patients and a voice for physicians.

The message also outlined several effective steps physicians must take to make reform work.

"DOCTOR BARNEY CAN SEE HER TOMORROW MORNING, WHEN THE BIG HAND IS ON THE SIX AND THE LITTLE HAND IS ON THE TEN."

126th Annual Session

THE NEBRASKA MEDICAL ASSOCIATION

DOMESTIC and ADOLESCENT VIOLENCE

APRIL 29 - MAY 1, 1994

Marriott Hotel
Omaha, Nebraska

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SCIENTIFIC SESSIONS COMMITTEE

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Lisa L. Strohmyer, R.N. ..... Papillion
Wesley G. Wilhelm, M.D. ..... Omaha

GENERAL INFORMATION

The host facility for the Annual Session is the Marriott Hotel, 10220 Regency Circle, Omaha, NE 68114, (402) 399-9000.

REGISTRATION: The registration desk will be located in the Ballroom Foyer of the Omaha Marriott Hotel. Registration begins at 7:00 a.m. on Friday, April 29. Identification badges must be worn by all persons attending the session.

Note: Specialty business meetings are limited to specialty group members only.

126TH ANNUAL SESSION
THE NEBRASKA MEDICAL ASSOCIATION

HISTORY:

Pursuant to a call made by the Omaha Medical Society, a number of delegates from the medical profession in the various counties in the state met at the rooms of Doctor Jas. H. Peabody, in Omaha, on the 11th day of May, 1868, for the purpose of taking some action towards the organization of a state medical society in Nebraska.

Three motions were passed, the first noted it was expedient and necessary to form a state medical society, the second elected a committee to draft a suitable constitution and bylaws, and the third directed a circular be distributed to Nebraska physicians calling for formation of county societies to send delegates to a convention for the purpose of forming a state medical society. The first Nebraska State Medical Convention was held on June 24, 1868, in Omaha and your state medical association was formed.

Although many things have changed, the functions of the Nebraska Medical Association remain consistent with those indicated in that initial circular;

* To cultivate the science of medicine;
* To elevate the standard of medical education;
* To promote public health;
* To improve medical knowledge; and
* To provide a vehicle for fellowship among its members.

Strong rationales that have withstood the tests of time.

PURPOSE:

The Scientific Sessions Committee of the Nebraska Medical Association, as its continuing medical education mission, seeks to satisfy the educational needs and interests of participants in the Nebraska Medical Association with scientifically-sponsored programs. Needs and interests are adjusted according to geographic and physician specialty requests on an annual review basis.

Functioning under the auspices of the Commission on Association Affairs, the Scientific Sessions Committee strives to accomplish the purposes of the Nebraska Medical Association with respect to continuing medical education. In pursuit of these purposes, the Committee has set forth the following goals.

1. To advance the science and art of medicine.
2. To elevate the standard of medical education.
3. To disseminate to NMA members and others, facts and opinions relating to medical knowledge, treatment and procedures.

The overall goal of this scientific program is to substantiate or change the attitude and approach of the physician to the solution of a given medical problem, present new knowledge in a specific area, update data, and introduce new specific skills and techniques.

SPONSORSHIP:

The meeting is sponsored by the Scientific Sessions Committee of the Nebraska Medical Association.

CREDIT:

This program has been reviewed and is acceptable for 5.75 Prescribed hours by the American Academy of Family Physicians.

The Scientific Sessions Committee is accredited by the Nebraska Medical Association Commission on Medical Education to sponsor continuing medical education for physicians.

The Scientific Sessions Committee designates this continuing medical education activity for 5.75 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Application for contact hours has been made to the Nebraska Nurses Association.

ROBERT F. SHAPIRO, M.D.
President, 1993-94

FREDERICK F. PAUSTIAN, M.D.
President, 1994-95

President

Robert F. Shapiro, M.D., Lincoln 1993-94
Frederick F. Paustian, M.D., Omaha 1994-95

Secretary-Treasurer

Chris C. Caudill, M.D., Lincoln 1996

Speaker, House of Delegates

Richard H. Meissner, M.D., Omaha 1995

Vice Speaker, House of Delegates

David R. Little, M.D., Hastings 1995

* * * *

Board of Councilors

District		Term Expires
I.	Roger S. Jernstrom, M.D., Omaha	1996
II.	John H. Casey, M.D., Lincoln	1996
III.	Paul M. Scott, M.D., Auburn	1996
IV.	Gordon D. Adams, M.D., Norfolk	1996
V.	Kenneth C. Bagby, M.D., Blair	1994
VI.	Richard M. Pitsch, M.D., Seward	1994
VII.	Richard A. Blatny, M.D., Fairbury	1994
VIII.	Richard D. Fitch, M.D., O'Neill	1994
IX.	Gordon D. Bainbridge, M.D., Grand Island	1995
X.	Charles F. Damico, M.D., Hastings	1995
XI.	Ronald L. Asher, M.D., North Platte	1995
XII.	Milton R. Johnson, M.D., Scottsbluff	1995

Chairman, Board of Councilors

Charles F. Damico, M.D., Hastings 1995

Board of Directors

Robert F. Shapiro, M.D., Lincoln ..... Chairman
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Ronald W. Klutman, M.D., Columbus 1994
Herbert A. Hartman, Jr., M.D., Omaha 1995
Robert G. Osborne, M.D., Lincoln 1996
Richard H. Meissner, M.D., Omaha ..... Ex-Officio
David R. Little, M.D., Hastings ..... Ex-Officio
Charles F. Damico, M.D., Hastings ..... Ex-Officio

* * *

Delegates to AMA

Paul E. Collicott, M.D., Lincoln 1995
Darroll J. Loschen, M.D., York 1995
Allen D. Dvorak, M.D., Omaha 1994
Blaine Y. Roffman, M.D., Omaha 1994

Alternate Delegates to AMA

NMA President
NMA President-Elect
NMA Secretary-Treasurer

* * *

Editor, Nebraska Medical Journal

Benjamin R. Gelber, M.D. ..... Lincoln

Executive Staff

William L. Schellpeper, Executive Director ..... Lincoln
James K. Ruigh, Assistant Executive Director ..... Lincoln

NEBRASKA MEDICAL ASSOCIATION BUSINESS SESSIONS

Board of Directors
Thursday, April 28, 3:00 p.m., Fremont Suite

Board of Councilors
Friday, April 29, 7:30 a.m., Columbus Suite

House of Delegates
First Session:
Friday, April 29, 1:00 p.m., Salons A, B, C, & D

RECOGNITION OF FIFTY-YEAR PRACTITIONERS

Warren G. Bosley, M.D., Grand Island
Ralph L. Cassel, M.D., Omaha
John D. Coe, M.D., Omaha
Edward K. Connors, M.D., Omaha
Merrill T. Eaton, M.D., Omaha
Richard J. Fangman, M.D., Omaha
Paul G. Goetowski, M.D., Walton
Wilbert E. Hieb, M.D., Henderson
Leland J. Olson, M.D., Omaha
Peyton T. Pratt, M.D., Omaha
Barney B. Rees, M.D., Omaha
Charles M. Root, M.D., Ft. Myers Beach, FL
William L. Rumbolz, M.D., Omaha
Jack M. Stemper, M.D., Lincoln
Stanley M. Truhlsen, M.D., Omaha
John G. Wiedman, M.D., Lincoln

Reference Committees, following the House of Delegates

NEBRASKA MEDICAL ASSOCIATION BUSINESS SESSIONS

Second Session:
Sunday, May 1, 7:30 a.m., Salons A, B, C, & D
Presentation of AMA Education and Research Foundation Checks
Presentation of Nebraska Medical Foundation Student Research Scholarship Checks
Presentation of C. A. McWhorter, M.D. Memorial Scholarship
Presentation of Frank H. Tanner, M.D. Memorial Scholarship
Presentation of Nebraska Medical Foundation/Lancaster County Medical Alliance Foundation Scholarship

Third Session:
Sunday, May 1, Salons A, B, C, & D (immediately follows second session)

Nominating Committee
First Session:
Friday, April 29, 4:00 p.m., Fremont Suite

Second Session:
Saturday, April 30, 8:00 a.m., Fremont Suite

Honors Luncheon
Past Presidents and 50-Year Practitioners Luncheon
Friday, April 29, 11:30 a.m., Salon E

Nebraska Medical Journal Editorial Board Luncheon
Friday, April 29, 11:30 a.m., Chardonnay Room

SPECIALTY SOCIETY BUSINESS SESSIONS

Nebraska Academy of Ophthalmology
Saturday, April 30, 7:30 a.m., Nebraska Suite A

Nebraska Society of Internal Medicine
Saturday, April 30, 7:30 a.m., Nebraska Suite B

ACKNOWLEDGEMENTS

The Nebraska Medical Association gratefully acknowledges the support of the following hospitals, foundations, and business interests for their contribution to the 1994 Annual Session.

FOUNDATIONS

Olney Foundation

HOSPITALS

Archbishop Bergan Mercy Hospital
Bishop Clarkson Memorial Hospital
Bryan Memorial Hospital
Childrens Hospital
Good Samaritan Health Systems
Immanuel Medical Center
Lincoln General Hospital
Mary Lanning Memorial Hospital
Methodist Richard Young
Nebraska Methodist Hospital
St. Elizabeth Community Health Center
St. Francis Medical Center
University Hospital/UNMC

ACKNOWLEDGEMENTS

BUSINESS INTERESTS

Blue Cross and Blue Shield of Nebraska
Chiron Vision
Mead Johnson Nutritionals
Medical Liability Mutual Insurance Company of Nebraska
Medical Protective Company
Merck Human Health Division
Mutual of Omaha Companies Group Operation
Pfizer Labs
Procter & Gamble Pharmaceuticals
Roerig Division, Pfizer Inc.
St. Paul Fire & Marine Insurance Company
W.L. Gore & Associates, Medical Products Division
Wyeth-Ayerst Laboratories
Xerox Corporation

DAILY SCHEDULE

FRIDAY, APRIL 29, 1994

General Registration
7:00 a.m., Ballroom Foyer, Omaha Marriott Hotel

Nebraska Medical Journal Editorial Board Luncheon
11:30 a.m., Chardonnay Room

Honors Luncheon
50-Year Practitioners and NMA Past Presidents Luncheon, 11:30 a.m., Salon E

NMA Business Sessions
Board of Councilors, 7:30 a.m., Columbus Suite
Lancaster County Medical Society Caucus, 11:30 a.m., Fremont Suite
Metro Omaha Medical Society Caucus, 11:30 a.m., Columbus Suite
Greater Nebraska Caucus, 10:30 a.m., Lincoln Suite
House of Delegates, 1:00 p.m., Salons A, B, C, & D
Nominating Committee, 4:00 p.m., Fremont Suite

UNMC COM Alumni Association
Class Agents Luncheon, 11:30 a.m., Beatrice Suite

Friday Evening

NMA/NMAA Dinner Party
6:00 p.m., 1338 North 139th Street, Omaha

PROGRAM

FRIDAY, APRIL 29

11:30 a.m. to 1:00 p.m. **Honors Luncheon - 50-Year Practitioners and NMA Past Presidents**
Salon E

11:30 a.m. to 1:00 p.m. **Nebraska Medical Journal Editorial Board Luncheon**
Chardonnay Room

11:30 a.m. **University of Nebraska Medical Center College of Medicine Alumni Class Agents Luncheon**
Beatrice Suite

6:00 p.m. **NMA/NMA Alliance Dinner Party**

Enjoy an evening of fine food and conversation at the home of Dr. & Mrs. David Finkle, 1338 North 139th Street in Omaha. Located in Linden Estates, the Finkles enjoy one of Omaha's most beautiful and prestigious homes. Relax with cocktails at 6:00 p.m. followed by a gourmet dinner created by well-known Omaha caterer Erwin Siegler.

DAILY SCHEDULE

SATURDAY, APRIL 30

General Registation:
7:00 a.m., Ballroom Foyer, Omaha Marriott Hotel

General Session Luncheon
12:00 noon, Salons D & E

NMA Business Sessions
Nominating Committee, 8:00 a.m., Fremont Suite

NMA Festivities
Presidents' Reception, 5:30 p.m., Salons A & B
Inaugural Dinner, 6:30 p.m., Salons C, D, & E

Scientific Session
Plenary Session, 9:00 a.m., Salons A, B, & C
Breakouts, 10:15 a.m., Salon A, Salon B, and Salon C
Panel Discussion/Question & Answer Session, 11:20 a.m., Salons A, B, & C
Plenary Session, 1:00 p.m., Salons A, B, & C
Breakouts, 2:10 p.m. and 3:10 p.m., Salon A, Salon B, and Salon C
Panel Discussion/Question & Answer Session, 4:00 p.m., Salons A, B, & C

UNMC COM Alumni
Board of Directors Meeting, 2:30 p.m., Columbus Suite
Annual Meeting, 4:00 p.m., Columbus Suite
Reception, 5:00 p.m., Fremont Suite

PROGRAM

SATURDAY, APRIL 30

Domestic and Adolescent Violence

The Nebraska Medical Association is pleased to present a program which is of vital interest to all physicians and other health care professionals. The Scientific Sessions Committee has again elected to provide a forum for discussion of societal problems that have a serious impact on us all. Physicians of all specialties and other health care providers are in a position to detect instances of potential and actual abuse and violence. The Committee has developed a program to help physicians and others recognize the symptoms of violence and act on them effectively, recognizing the fine balance of family dynamics and the law.

Morning Plenary Session

9:00 a.m. - 10:00 a.m.
Salons A, B & C

"Domestic Violence: An Overview"
Moderator - David L. Bacon, M.D., Kearney
Speaker - Marian Sassetti, M.D., Chicago, Illinois

Objectives
- Define domestic violence;
- Discuss the prevalence of domestic violence and its societal influences;
- Describe societal and economic implications of domestic violence; and
- Discuss the legal obligations of health care professionals with respect to domestic violence.

Morning Breakout Sessions

10:15 a.m. - 11:15 a.m.
Salon A

"Spouse Abuse"
Moderator - Lawrence D. Helmick, M.D., Kearney
Speaker - Marian Sassetti, M.D., Chicago, Illinois

Objectives
- Discuss recognition of spouse abuse;
- Describe the health care professional's responsibility and liability in reporting spouse abuse;
- Discuss the accurate and appropriate gathering of evidence; and
- Address the issue of the health care professional as a credible witness.

10:15 a.m. - 11:15 a.m.
Salon B

"Child Abuse"
Moderator - Lawrence C. Bausch, M.D., Lincoln
Speakers - Debra J. P. Tomek, M.D., Omaha
- Michael J. Moran, M.D., Omaha

Objectives
- Discuss recognition of physical and sexual child abuse;
- Describe the health care professional's responsibility and liability in reporting physical and sexual child abuse;
- Discuss the accurate and appropriate gathering of evidence; and
- Address the issue of the health care professional as a credible witness.

10:15 a.m. - 11:15 a.m.
Salon C

"Abuse of the Elderly"
Moderator - Charles D. Gregorius, M.D., Lincoln
Speaker - Susan G. Scholer, M.D., Omaha

Objectives
- Discuss recognition of physical abuse and neglect of the elderly;
- Describe the health care professional's responsibility and liability in reporting abuse and neglect of the elderly;
- Discuss the accurate and appropriate gathering of evidence; and
- Address the issue of the health care professional as a credible witness.

11:20 a.m. - 12:00 noon
Salons A, B, & C
"Panel Discussion/Question & Answer Session"
Moderator - Wesley G. Wilhelm, M.D., Omaha
Speakers - Marian Sassetti, M.D., Chicago, Illinois
- Debra J.P. Tomek, M.D., Omaha
- Michael J. Moran, M.D., Omaha
- Susan G. Scholer, M.D., Omaha

Participants will be encouraged to question and interact with speakers. The learning objective will be identifying the commonalities associated with the information presented in each breakout session.

General Session Luncheon

12:00 noon - 1:00 p.m.
Salons D & E
- Those in attendance are invited to have lunch together and discuss the morning's presentations. Tickets must be purchased in advance.

"Teen Health Challenges and Adolescent Violence"

Program Goals

- Describe the nature of high risk behaviors among youth including adolescent violence and its basic causes;
- Outline the role of the health care professional in addressing the issue of high risk behavior and adolescent violence through a health care perspective; and
- Review effective communication skills applicable to adolescents.

Afternoon Plenary Session

1:00 p.m. - 2:00 p.m.
Salons A, B, & C
Moderator - Charles G. Erickson, M.D., Lincoln

"Adolescents at Risk: What Do We Say to Them?"
Speaker - Ian Newman, Ph.D., Lincoln

Objectives - Discuss the incidence of high risk behaviors in adolescents;
- Discuss the most effective educational approaches in helping adolescents.

"Adolescent Violence in Nebraska: The Role of the Health Professional"
Speakers - B. Shari Burns, M.D., Omaha
- Roosevelt Green, M.D., Papillion
- Rita Westover, R.N., B.S.N. Lincoln

Objectives - Discuss methods of identifying relevant issues related to youth violence, strategies for enhancing accessibility and the appropriateness of health care given;
- Discuss methods of identifying youth at risk for perpetrating violence or of becoming the victims of violence;
- Discuss one viewpoint of youth violence from the perspective of a pediatric residency experience and that of an office practice.

Afternoon Breakout Sessions

2:10 p.m. - 2:55 p.m. & 3:10 p.m. - 3:55 p.m.
Salon A

"Substance Usage in Adolescents"

Speakers
- Richard W. Hammer, M.D., Lincoln
- Kelly Madigan Erlandson, C.A.D.A.C., Lincoln
- Mickey Seefeld, R.N., C.D., Lincoln

Objectives
- Outline the early signs of substance abuse in adolescents;
- Review techniques to screen for substance abuse in adolescents;
- Discuss the health care professional's role in making appropriate referrals.

2:10 p.m. - 2:55 p.m. & 3:10 p.m. - 3:55 p.m.
Salon B

"Depression in Adolescents"

Speakers
- Charles G. Erickson, M.D., Lincoln
- David G. Rutz, M.D., Lincoln

Objectives
- Discuss the concept that depression is in part a biologic illness with a need for medical involvement;
- Outline the early recognition of signs of depression;
- Review techniques to screen for adolescent depression;
- Discuss the health care professional's role in making appropriate referrals.

2:10 p.m. - 2:55 p.m. & 3:10 p.m. - 3:55 p.m.
Salon C

"Adolescent Sexuality"

Speakers
- Roosevelt Green, M.D., Papillion
- B. Shari Burns, M.D., Omaha
- Rita Westover, R.N., B.S.N., Lincoln

Objectives
- Discuss the issues associated with adolescent sexuality;
- Review techniques which enable the health care professional to more comfortably address sexual issues with the adolescent.

4:00 p.m. - 4:30 p.m.
Salons A, B, & C

"Panel Discussion/Question & Answer Session"

Moderator - Charles G. Erickson, M.D., Lincoln

Speakers
- B. Shari Burns, M.D., Omaha
- Roosevelt Green, M.D., Papillion
- Richard W. Hammer, M.D., Lincoln
- David G. Rutz, M.D., Lincoln
- Ian Newman, Ph.D., Lincoln
- Kelly Madigan Erlandson, C.A.D.A.C., Lincoln
- Mickey Seefeld, R.N., C.D., Lincoln
- Rita Westover, R.N., B.S.N., Lincoln

Participants will be encouraged to question and interact with speakers. The learning objective will be identifying the commonalities associated with the information presented in each breakout session.

INAUGURAL FESTIVITIES

SATURDAY EVENING, APRIL 30

5:30 p.m. **Presidents' Reception** — Salons A & B
For Physicians and their Spouses
Honoring the President of the Nebraska Medical Association and the President of the Nebraska Medical Association Alliance

6:30 p.m. **Inaugural Ceremonies** — Salons C, D, & E

Installation of Frederick F. Paustian, M.D. as the President of the Nebraska Medical Association

Recognition of Sally I. Semm as President of the Nebraska Medical Association Alliance

Presiding - John C. Sage, M.D., Omaha
President, Metro Omaha Medical Society

7:00 p.m. **Inaugural Dinner** — featuring "Cuisines of the World"

Frederick F. Paustian, M.D.

Sally I. Semm

Cabaret Theatre, Omaha's premiere cabaret troupe, are the featured performers at the Inaugural Banquet. The group will present segments of its most recent original review, ***Hit The Road To Dreamland,*** which includes a medley of dreamsongs, a salute to the blues, and stunning vocal jazz arrangements of such numbers as *The More I See You, All The Things You Are, Candy, Blues in The Night, Birth of the Blues,* and *Stormy Weather.* The production stars Omaha performers Beth Asbjornson, Camille Metoyer Moten, Phyllis Noble, Rebecca Noble, and pianist Ginny May. The four singers are members of Soli Deo Gloria Cantorum, Nebraska's professional chorale. As individual performers, they have been seen onstage at virtually every theater in the Omaha area.

Cabaret Theatre was founded in the fall of 1991 and has produced seven unique, sophisticated productions since that time. Recent performances include the Sioux Falls Community Playhouse Benefit; Hastings Symphony Benefit; Joslyn Art Museum's *Thursday Night Live* series; Fremont Dinner Train; Dundee Theatre; and Firehouse Dinner Theatre.

Cabaret Theatre

*A grant from the Olney Foundation has been utilized to provide the entertainment and to partially offset the cost of the Inaugural Dinner and Ceremonies. The Association expresses its appreciation for this support.

DAILY SCHEDULE

SUNDAY, MAY 1

NMA Business Sessions

House of Delegates, 7:30 a.m., Salons A, B, C, & D

69th

Annual Meeting

of the

Nebraska Medical Association Alliance

If your physician spouse is eligible to be a Nebraska Medical Association member, you are eligible to be a member of the Alliance. Please join us for any or all of the scheduled activities.

We Welcome You!

REGISTRATION:

Friday, April 29, 8:30 a.m. through 12:15 p.m.
Marriott Hotel

BARBARA BOHI (MRS. DANIEL)
Omaha
President 1993-94

SALLY SEMM (MRS. H. RUSSELL)
Lincoln
President 1994-95

MARY HANSON (MRS. JEROME)
President, AMA Alliance
Colorado Springs, Colorado

ALLIANCE PROGRAM

FRIDAY, APRIL 29

8:30 a.m. to 12:15 p.m.	**Registration** — Marriott Hotel
8:30 a.m.	**Gavel Club Business Meeting** - Nebraska Suite A & B Elba Lau, Presiding
9:30 a.m.	**Annual Business Meeting** — Nebraska Suite A & B Barbara Bohi, NMAA President, Presiding
12:15 p.m.	**NMAA Awards and Installation Luncheon** — Gambits Speaker - Mary Hanson, President, AMA Alliance Presentation of Awards Installation of Officers
2:30 p.m.	**Post Convention Board Meeting** - Nebraska Suite A & B Sally Semm, 1994-95 NMAA President, Presiding
3:00 p.m.	**Gavel Club Social Hour** - Allie's
6:00 p.m.	**NMA/NMA Alliance Dinner Party**

Enjoy an evening of fine food and conversation at the home of Dr. & Mrs. David Finkle, 1338 North 139th Street in Omaha. Located in Linden Estates, the Finkles enjoy one of Omaha's most beautiful and prestigious homes. Relax with cocktails at 6:00 p.m. followed by a gourmet dinner created by well-known Omaha caterer Erwin Siegler.

ALLIANCE PROGRAM

SATURDAY, APRIL 30
DOMESTIC AND ADOLESCENT VIOLENCE

9:00 a.m. **Plenary Session**
"Domestic Violence: An Overview

10:15 a.m. **Breakout Sessions**
"Spouse Abuse"
"Child Abuse"
"Abuse of the Elderly"

11:20 a.m. **Morning Session Overview**

12:00 noon **Luncheon** - $14.50

1:00 p.m. **Plenary Session**
"Adolescent Violence in Nebraska: The Role of the Health Care Professional"
"Adolescents at Risk: What Do We Say To Them?"

2:10 and 3:10 p.m. **Breakout Sessions**
"Substance Usage in Adolescents"
"Depression in Adolescents"
"Adolescent Sexuality"

4:00 p.m. **Afternoon Session Overview**

5:30 p.m. **Presidents' Reception** — Salons A & B
Honoring the President of the Nebraska Medical Association and the President of the Nebraska Medical Association Alliance

6:30 p.m. **Inauguration** — Salons C, D, & E
Installation of Frederick F. Paustian, M.D. as President of the Nebraska Medical Association

Recognition of Sally Semm as President of the Nebraska Medical Association Alliance

7:00 p.m. **Inaugural Dinner** — featuring "Cuisines of the World", followed by ***Cabaret Theatre***, Omaha's premiere cabaret troupe. The group will present segments of its most recent original review, ***Hit The Road To Dreamland***, which includes a medley of dreamsongs, a salute to the blues, and stunning vocal jazz arrangements of such numbers as *The More I See You, All The Things You Are, Candy, Blues in The Night, Birth of the Blues, and Stormy Weather.*

ALLIANCE PROGRAM

SUNDAY, MAY 1

7:30 a.m. **House of Delegates, Nebraska Medical Association**
Salons A, B, C, & D
Presentation of AMA Education and Research Foundation Checks
Presentation of Nebraska Medical Foundation Student Research Scholarship Program Checks
Presentation of C. A. McWhorter, M.D., Memorial Scholarship
Presentation of Frank H. Tanner, M.D., Memorial Scholarship
Presentation of Lancaster County Medical Alliance Foundation/Nebraska Medical Foundation Memorial Scholarship

NMAA Presidential Report - Barbara Bohi

NEBRASKA MEDICAL ASSOCIATION ALLIANCE

HISTORY — THE BEGINNING

In May, 1922, the "Womens' Auxiliary" to the American Medical Association was formed. It was inevitable the doctors' wives in Nebraska would want to be a part of this movement. The first annual meeting in Nebraska was held May 10, 1926. Reports at the meeting indicated a membership of 225.

The very first list of objectives were the following:

. . . "A spirit of friendliness among physicians' families
. . . an auxiliary to every county medical society in the state
. . . a physical examination for every member of the physician's family on his or her birthday
. . . cooperation with the Anti-Tuberculosis Society
. . . a copy of Hygeian in every public library and rural school in the state."

Today our purposes include:

. . . Assisting those programs of the NMA that improve the health and quality of life for people
. . . promoting health education
. . . encouraging volunteerism
. . . supporting health-related charitable endeavors
. . . working with the AMA Alliance
. . . working with the medical student and house officer spouses
. . . serving as a reliable liaison between the medical profession and the lay public

Currently, membership in the Nebraska Medical Association Alliance is about 1,000. We use the term **spouse** instead of wife as today many physicians are women and we are proud to include the husband as an Alliance member.

PAST PRESIDENTS OF THE NEBRASKA MEDICAL ASSOCIATION ALLIANCE

Mrs. F.A. Long, Madison 1925-26
Mrs. C. Robendall, Omaha 1926-27
Mrs. G. Walker, Lincoln 1927-28
Mrs. S.A. Preston, Fremont 1928-29
Mrs. H. P. Overgaard, Omaha 1929-30
Mrs. E. W. Rowe, Lincoln 1930-31
Mrs. M. Nielson, Blair 1931-32
Mrs. C. Roeder, California 1932-33
Mrs. B. F. Williams, Lincoln 1933-34
Mrs. H. B. Miner, Falls City 1934-35
Mrs. C. C. Tomlinson, Omaha 1935-36
Mrs. J. M. Woodward, Lincoln 1936-37
Mrs. E. E. Farnsworth (Jessie) G. Island ... 1937-38
Mrs. C. W. Pollard (Helen), Peru 1938-39
Mrs. J. E. M. Thompson (Helen), Calif 1939-40
Mrs. H. McCullough (Fannie), Cen. City 1940-41
(formerly Mrs. A. D. Brown)
Mrs. M. C. Green (Mary), California 1941-42
Mrs. W. W. Carveth (Rachel), Lincoln 1942-43
Mrs. W. W. Carveth (Rachel), Lincoln 1943-44
Mrs. H. Davis (Olga), Omaha 1944-45
Mrs. H. McCullough (Fannie), Cent. City ... 1945-46
(formerly Mrs. A. D. Brown)
Mrs. E. S. Wegner, Lincoln 1946-47
Mrs. M. E. Grier, Omaha 1947-48
Mrs. P. O. Marvel, Giltner 1948-49
Mrs. C. F. Ferciot (Charlene), Calif. 1949-50
Mrs. G. D. Whitcomb, Omaha 1950-51
Mrs. B. R. Bancroft (Sue), Kearney 1951-52
Mrs. R. E. Garlinghouse (Miriam), Lincoln 1952-53
Mrs. J. P. Donelan (Genevieve), Omaha 1953-54
Mrs. Isaih Lukens IV, Tekamah 1954-55
Mrs. L. E. Sharrar (Mary Ellen), Lincoln ... 1955-56
Mrs. G. E. Robertson (Kate), Omaha 1956-57
Mrs. H. E. Harris (Helen), Grand Island 1957-58
(formerly Mrs. R. R. Brady, Ainsworth)
Mrs. G. W. Covey (Elizabeth), Lincoln 1958-59
Mrs. C. H. Farrel (Margaret), Omaha 1959-60
Mrs. W. W. Waddell (Jean), Beatrice 1960-61
Mrs. F. H. Tanner (Ruth), Lincoln 1961-62
Mrs. Betty Lindain, Omaha 1962-63
(formerly Mrs. John M. Christlieb)
Mrs. R. E. Rundquist (Opal), Columbus 1963-64
Mrs. W. Hogg (Gladys), Columbus 1964-65
(formerly Mrs. John A. Brown, III)
Mrs. J. W. Kelley (Irene), Omaha 1965-66
Mrs. F. Smith (Jo), Omaha 1966-67
Mrs. A. L. Smith, Sr. (Beth), Lincoln 1967-68
Mrs. P. B. Olsson (Gladys), Arizona 1968-69
Mrs. R. H. McIntire (Marilyn), Hastings 1969-70
Mrs. S. Filkins, Omaha 1970-71
Mrs. L. Olson (Dorothy), Omaha 1971-72
Mrs. J. Carlson (Barbara), Lincoln 1972-73
Mrs. W. Bosley (Alleen), Grand Island 1973-74
Mrs. K. T. McGinnis (Helen), Lincoln 1974-75
Mrs. Y. S. Moore (Patsy), Lincoln 1975-76
Mrs. G. Francis (Harriette), Grand Island . 1976-77
Mrs. G. Matson (Dorothy), Lincoln 1977-78
Mrs. H. D. Shaffer (Dorothy), Lincoln 1978-79
Mrs. F. W. Karrer (Bev), Omaha 1979-80
Mrs. C. Hadley (Betty), Lyons 1980-81
Mrs. L. P. Johnson (Shirley), Lincoln 1981-82
Mrs. B. Shopp (Wanda), Imperial 1982-83
Mrs. G. Lau (Elba), Lincoln 1983-84
Mrs. D. Krause (Helen), Fremont 1984-85
Mrs. L. I. Grace (Ardis), Blair 1985-86
Mrs. R. Kruger (Bev), Omaha 1986-87
Mrs. G. Adam (Colleen), Hastings 1987-88
Mrs. R. Osborne (Desta), Lincoln 1988-89
Mrs. W. Becker (Sally), Norfolk 1989-90
Mrs. W. Schlichtemeier (Jeanette), Omaha 1990-91
Mrs. F. Stone (Donna), Lincoln 1991-92
Mrs. C. Damico (Mona), Hastings 1992-93

PAST PRESIDENTS OF THE NEBRASKA MEDICAL ASSOCIATION

Gilbert C. Monell, M.D., Omaha 1868-69
James H. Peabody, M.D., Omaha 1869-70
N. B. Larsh, M.D., Nebraska City 1870-71
R. B. Livingston, M.D., Plattsmouth 1871-72
A. Bowen, M.D., Nebraska City 1872-73
H. P. Mathewson, M.D., Omaha 1873-74
John Black, M.D., Plattsmouth 1874-75
L. H. Robbins, M.D., Lincoln 1875-76
J. P. Peck, M.D., Omaha 1876-77
L. J. Abbott, M.D., Fremont 1877-78
E. M. Whitten, M.D., Nebraska City 1878-79
Harvey Link, M.D., Millard 1879-80
S. D. Mercer, M.D., Omaha 1880-81
M. W. Stone, M.D., South Omaha 1881-82
A. H. Sowers, M.D., Lincoln 1882-83
Victor H. Coffman, M.D., Omaha 1883-84
F. G. Fuller, M.D., Grand Island 1884-85
W. W. Knapp, M.D., Lincoln 1885-86
Richard C. Moore, M.D., Omaha 1886-87
George H. Peebles, M.D., Lincoln 1887-88
Milton Lane, M.D., Kearney 1888-89
J. C. Denise, M.D., Omaha 1889-90
D. A. Walden, M.D., Beatrice 1890-91
Charles Inches, M.D., Scribner 1891-92
M. L. Hildreth, M.D., Lyons 1892-93
A. S. von Mansfelde, M.D., Ashland 1893-94
H. B. Lowry, M.D., Lincoln 1894-95
J. E. Summers, M.D., Omaha 1895-96
F. D. Haldeman, M.D., Ord 1896-97
Wilson O. Bridges, M.D., Omaha 1897-98
A. R. Mitchell, M.D., Lincoln 1898-99
Robert McConaughy, M.D., York 1899-00
H. M. McClanahan, M.D., Omaha 1900-01
Wm. B. Eby, M.D., Ainsworth 1901-02
A. B. Anderson, M.D., Pawnee City 1902-03
B. F. Crummer, M.D., Omaha 1903-04
R. C. McDonald, M.D., Fremont 1904-05
A. F. Jonas, M.D., Omaha 1905-06
F. A. Long, M.D., Madison 1906-07
Harold Gifford, M.D., Omaha 1907-08
L. M. Shaw, M.D., Osceola 1908-09
P. H. Salter, M.D., Norfolk 1909-10
J. P. Lord, M.D., Omaha 1910-11
A. D. Nesbit, M.D., Tekamah 1911-12
I. N. Pickett, M.D., Odell 1912-13
D. C. Bryant, M.D., Omaha 1913-14
J. P. Gilligan, M.D., O'Neill 1914-15
E. W. Rowe, M.D., Lincoln 1915-16
W. F. Milroy, M.D., Omaha ..... 1916-17 (to 12-31-17)
C. L. Mullins, M.D., Broken Bow 1918
J. M. Bannister, M.D., Omaha 1919
H. W. Orr, M.D., Lincoln 1920
M. S. Moore, M.D., Gothenburg 1921
B. B. Davis, M.D., Omaha 1922
B. F. Bailey, M.D., Lincoln 1923
Morris Nielsen, M.D., Blair 1924
Palmer Findley, M.D., Omaha 1925
H. J. Lehnhoff, M.D., Lincoln 1926
H. E. Potter, M.D., Fairbury 1927
B. R. McGrath, M.D., Grand Island ..... 1928-29 (to 5-14-29)
F. S. Owen, M.D., Omaha 1929-30
K. S. J. Hohlen, M.D., Lincoln 1930-31
Lucien Stark, M.D., Norfolk 1931-32
A. E. Cook, M.D., Randolph 1932-33
Adolph Sachs, M.D., Omaha 1933-34
Joseph Bixby, M.D., Geneva 1934-35
Claude A. Selby, M.D., North Platte 1935-36
George W. Covey, M.D., Lincoln 1936-37
R. W. Fouts, M.D., Omaha 1937-38
Homer Davis, M.D., Genoa 1938-39
A. L. Miller, M.D., Kimball 1939-40
Clayton F. Andrews, M.D., Lincoln 1940-41
W. P. Wherry, M.D., Omaha 1941-42
Dexter D. King, M.D., York 1942-43
A. L. Cooper, M.D., Scottsbluff 1943-44
Floyd L. Rogers, M.D., Lincoln 1944-45
Charles McMartin, M.D., Omaha 1945-46
Earle G. Johnson, M.D., Grand Island 1946-47
G. E. Charlton, M.D., Norfolk 1947-48
J. E. M. Thomson, M.D., Lincoln 1948-49
J. D. McCarthy, M.D., Omaha 1949-50
C. H. Sheets, M.D., Cozad 1950-51
D. B. Steenburg, M.D., Aurora 1951-52
Harold S. Morgan, M.D. Lincoln 1952-53
James F. Kelly, M.D., Omaha 1953-54
Earl F. Leininger, M.D., McCook 1954-55
Wm. E. Wright, M.D., Creighton 1955-56
J. M. Woodward, M.D., Lincoln 1956-57
R. Russell Best, M.D., Omaha 1957-58
Fay Smith, M.D., Imperial 1958-59
E. E. Koebbe, M.D., Columbus 1959-60
Fritz Teal, M.D., Lincoln 1960-61

PAST PRESIDENTS OF THE NEBRASKA MEDICAL ASSOCIATION

A. J. Offerman, M.D., Omaha 1961-62
O. A. Kostal, M.D., Hastings 1962-63
R. F. Sievers, M.D., Blair 1963-64
R. E. Garlinghouse, M.D., Lincoln 1964-65
Willis D. Wright, M.D., Omaha 1965-66
Dan A. Nye, M.D., Kearney 1966-67
Robert J. Morgan, M.D., Alliance 1967-68
Frank H. Tanner, M.D., Lincoln 1968-69
J. Whitney Kelley, M.D., Omaha 1969-70
Clarence R. Brott, M.D., Beatrice 1970-71
Roger D. Mason, M.D., McCook 1971-72
Frank P. Stone, M.D., Lincoln 1972-73
John D. Coe, M.D., Omaha 1973-74
James H. Dunlap, M.D., Norfolk 1974-75
Warren G. Bosley, M.D., Grand Island 1975-76
Harlan L. Papenfuss, M.D., Lincoln 1976-77
Arnold W. Lempka, M.D., Omaha 1977-78
Houtz G. Steenberg, M.D., Aurora 1978-79
Charles W. Landgraf, Jr., M.D., Hastings 1979-80
Russell L. Gorthey, M.D., Lincoln 1980-81
Carlyle E. Wilson, Jr., M.D., Omaha 1981-82
Allan C. Landers, M.D., Scottsbluff 1982-83
Dwaine J. Peetz, M.D., Neligh 1983-84
Herbert E. Reese, M.D., Lincoln 1984-85
Francis D. Donahue, M.D., Omaha 1985-86
Hiram R. Walker, M.D., Kearney 1986-87
L. Dwight Cherry, M.D., Lincoln 1987-88
C. A. McWhorter, M.D., Omaha 1988
Donald J. Pavelka, M.D., Omaha 1988-89
Richard A. Raymond, M.D., O'Neill 1989-90
Paul E. Collicott, M.D., Lincoln 1990-91
Perry T. Williams, M.D., Omaha 1991-92
Darroll J. Loschen, M.D., York 1992-93

GUEST FACULTY

B. Shari Burns, M.D.
Omaha, Nebraska

Charles Erickson, M.D.
Lincoln, Nebraska

Kelly Madigan Erlandson, C.A.D.A.C.
Lincoln General Hospital
Lincoln, Nebraska

Roosevelt Green, M.D.
Papillion, Nebraska

Richard Hammer, M.D.
Lincoln, Nebraska

Michael J. Moran, M.D.
Creighton University
School of Medicine
Omaha, Nebraska

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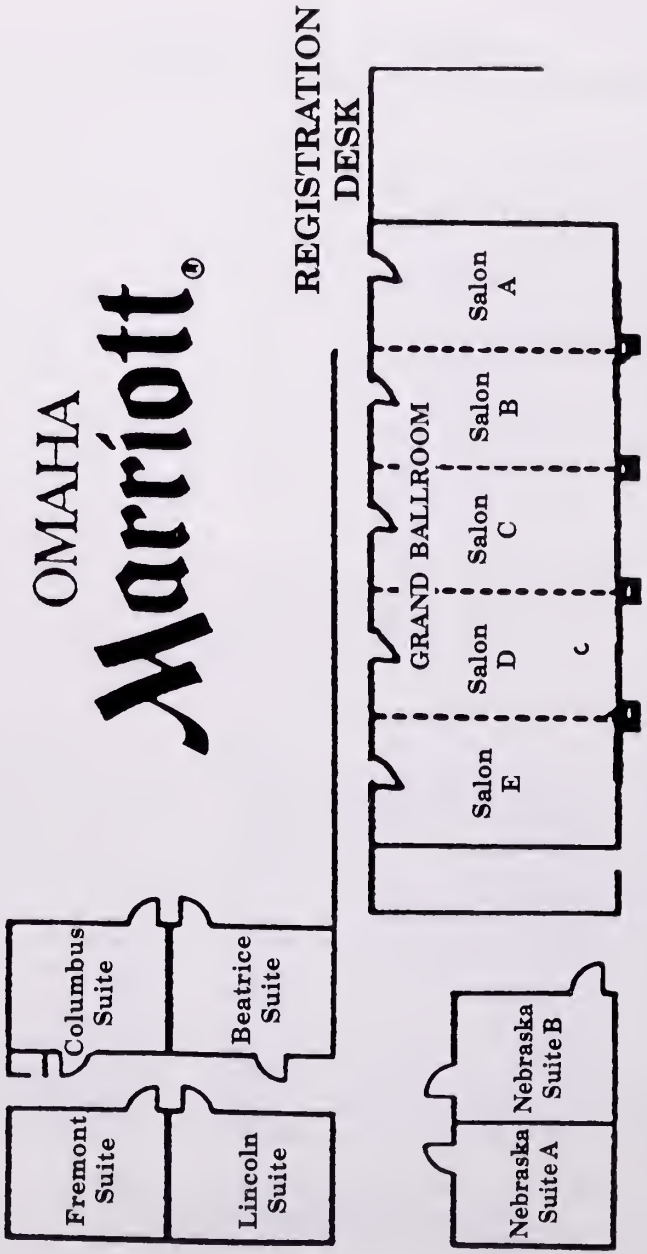

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1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
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6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
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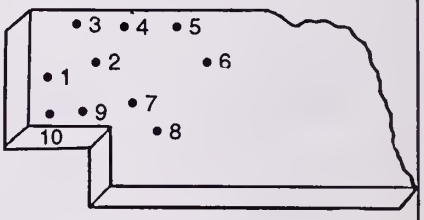

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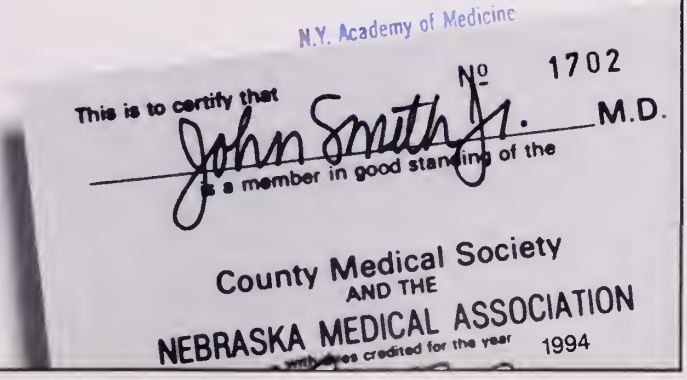

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The Nebraska Medical Journal

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- **Rapid-acting†**

  CLARITIN Tablets started working in some patients in as soon as 30 minutes; 65% of patients experienced relief within 2 hours.[1]

- **Once-a-day dosing**
- **Low incidence of adverse effects**

  In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

- **Over 1 billion patient days of worldwide experience**

Clear Benefits From Start To Finish

Once-a-day

Claritin®

10 mg TABLETS (loratadine)

* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

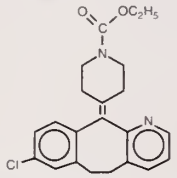
Please see following page for brief summary of Prescribing Information.

CLARITIN®
brand of loratadine
TABLETS
Long-Acting Antihistamine

PRODUCT INFORMATION

DESCRIPTION CLARITIN Tablets contain 10 mg micronized loratadine, an antihistamine, to be administered orally. They also contain the following inactive ingredients: corn starch, lactose, and magnesium stearate.

Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 382.89, and empirical formula of $C_{22}H_{23}ClN_2D_2$; its chemical name is ethyl 4-(8-chloro-5,6-dihydro-11*H*-benzo[5,6]cyclohepta[1,2-*b*]pyridin-11-ylidene)-1-piperidinecarboxylate and has the following structural formula:



CLINICAL PHARMACOLOGY Loratadine is a long-acting tricyclic antihistamine with selective peripheral histamine H_1-receptor antagonistic activity.

Human histamine skin wheal studies following single and repeated 10 mg oral doses of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with CLARITIN Tablets.

Pharmacokinetic studies following single and multiple oral doses of loratadine in 115 volunteers showed that loratadine is rapidly absorbed and extensively metabolized to an active metabolite (descarboethoxyloratadine). The specific enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found equally distributed between urine and feces in the form of metabolic products after 10 days. The mean elimination half-lives found in studies in normal adult subjects (n = 54) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) to the metabolite is greater than exposure to parent loratadine.

In a study involving twelve healthy geriatric subjects (66 to 78 years old), the AUC and peak plasma levels (Cmax) of both loratadine and descarboethoxyloratadine were significantly higher (approximately 50% increased) than in studies of younger subjects. The mean elimination half-lives for the elderly subjects were 18.2 hours (range = 6.7 to 37 hours) for loratadine and 17.5 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth daily dose. The pharmacokinetics of loratadine and descarboethoxyloratadine are dose independent over the dose range of 10 to 40 mg and are not significantly altered by the duration of treatment.

In the clinical efficacy studies, CLARITIN Tablets were administered before meals. In a single-dose study, food increased the AUC of loratadine by approximately 40% and of descarboethoxyloratadine by approximately 15%. The time to peak plasma concentration (Tmax) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences would not be expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In patients with chronic renal impairment (Creatinine Clearance ≤ 30 mL/min) both the AUC and peak plasma levels (Cmax) increased on average by approximately 73% for loratadine; and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from that observed in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In patients with chronic alcoholic liver disease the AUC and peak plasma levels (Cmax) of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly changed from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours, respectively, and increased with increasing severity of liver disease.

There was considerable variability in the pharmacokinetic data in all studies of CLARITIN Tablets, probably due to the extensive first-pass metabolism. Individual histograms of area under the curve, clearance, and volume of distribution showed a log normal distribution with a 25-fold range in distribution in healthy subjects.

Loratadine is about 97% bound to plasma proteins at the expected concentrations (2.5 to 100 ng/mL) after a therapeutic dose. Loratadine does not affect the plasma protein binding of warfarin and digoxin. The metabolite descarboethoxyloratadine is 73% to 77% bound to plasma proteins (at 0.5 to 100 ng/mL).

Whole body autoradiographic studies in rats and monkeys, radiolabeled tissue distribution studies in mice and rats, and *in vivo* radioligand studies in mice have shown that neither loratadine nor its metabolites readily cross the blood-brain barrier. Radioligand binding studies with guinea pig pulmonary and brain H_1-receptors indicate that there was preferential binding to peripheral versus central nervous system H_1-receptors.

Clinical trials of CLARITIN Tablets involved over 10,700 patients who received either CLARITIN Tablets or another antihistamine and/or placebo in double-blind randomized controlled studies. In placebo-controlled trials, 10 mg once daily of CLARITIN Tablets was superior to placebo and similar to clemastine (1 mg BID) or terfenadine (60 mg BID) in effects on nasal and non-nasal symptoms of allergic rhinitis. In these studies, somnolence occurred less frequently with CLARITIN Tablets than with clemastine and at about the same frequency as terfenadine or placebo. In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence.

In a study in which CLARITIN Tablets were administered at 4 times the clinical dose for 90 days, no clinically significant increase in the QTc was seen on ECGs.

INDICATIONS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS **General:** Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based o
or race, although the number of non-white subjects was relative

In addition to those adverse events reported above, the followi
events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased
altered lacrimation, hypoesthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache
tinnitus, asthenia, weight gain, back pain, leg cramps, malaise,
rigors, fever, aggravated allergy, upper respiratory infection, an
edema.

Cardiovascular System Hypotension, hypertension, palpita
cope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, bleph
paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vom
lence, gastritis, constipation, diarrhea, altered taste, increase
anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paroni
impaired concentration, confusion, decreased libido, nervousne

Reproductive System Breast pain, menorrhagia, dysmenorrhe

Respiratory System Nasal dryness, epistaxis, pharyngitis
nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, snee
chospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria
ritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have be
rarely during the marketing of loratadine: peripheral edema; ab
patic function, including jaundice, hepatitis, and hepatic necrosis
seizures; breast enlargement; erythema multiforme; and anaphy

DRUG ABUSE AND DEPENDENCE There is no information to i
abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache hav
ported with overdoses greater than 10 mg (40 to 180 mg). In t
overdosage, general symptomatic and supportive measures
instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of eme
syrup), except in patients with impaired consciousness, followed
ministration of activated charcoal to absorb any remaining drug.
is unsuccessful, or contraindicated, gastric lavage should be
with normal saline. Saline cathartics may also be of value for ra
of bowel contents. Loratadine is not eliminated by hemodialys
known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg
mice. Doses as high as 10 times the recommended clinical dos
no effects in rats, mice, and monkeys.

DOSAGE AND ADMINISTRATION Adults and children 12 years
over: One 10 mg tablet daily on an empty stomach.

In patients with liver failure, 10 mg every other day should b
ing dose.

HOW SUPPLIED CLARITIN Tablets, 10 mg, white to off-white c
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ages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-
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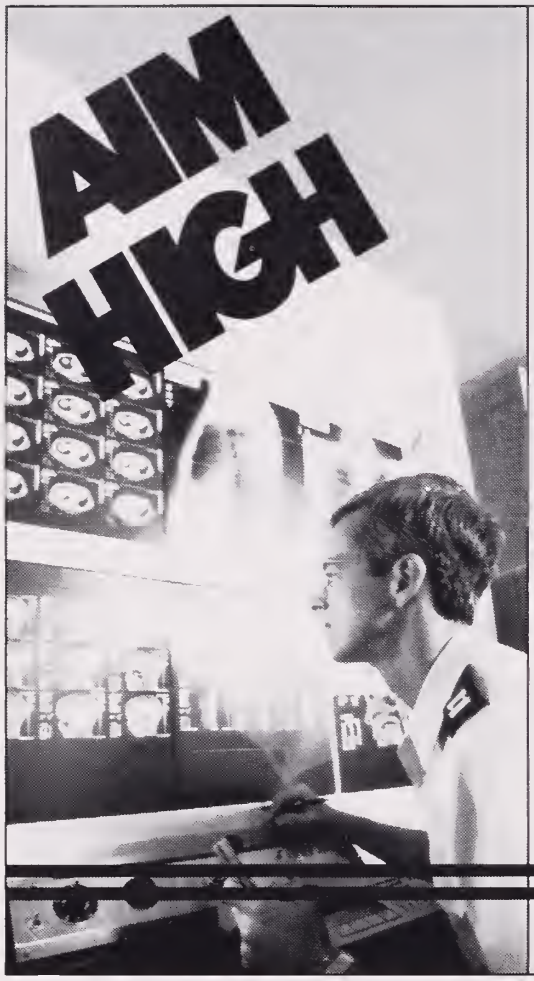

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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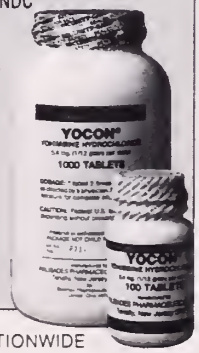

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Home Phone ( )	Other Income		Income from alimony, child support, or separate maintenance payments need not be revealed If you do not choose to have it considered as a basis for repaying this obligation $

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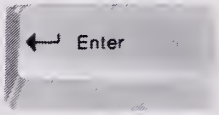

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Nebraska Medical Association President, Frederick F. Paustian, M.D., receives a plaque commemorating increased membership by Nebraska physicians in the American Medical Association. The award was presented at the AMA Leadership Conference in San Francisco by Lonnie Bristow, M.D., Chair, AMA Board of Trustees.

Timothy A. Burd, a student of Creighton University School of Medicine, received the AMA/Glaxo Achievement Award from Lonnie Bristow, M.D., Chair, AMA Board of Trustees at the AMA Leadership Conference in San Francisco. The award is presented to 25 medical students annually in recognition of exceptional leadership abilities or achievements in non-clinical community activities.

PRESIDENT'S PAGE

Health Care Delivery Reform - Adaptation Not Capitulation

FREDERICK F. PAUSTIAN, M.D.

The following inaugural address was presented April 30, 1994

Health care delivery reform, as conceived by the medical delivery industry and the government, has been the major topic of debate and concern among physicians for the past year and it can be anticipated it will continue to the major topic for at least the next 5 years.

I was rather amused at the humor expressed by Dr. Donald J. Schroeder, President of the Oregon Medical Association, when he addressed the AOA initiates at the Creighton University School of Medicine in early March 1994. So as to avoid any potential insensitivity regarding gender, race, ethnic, and cultural factors, he related the story of the little girl strawberry commenting to the little boy strawberry, "If you had stayed in your bed and I had stayed in mine we wouldn't be in this jam today". I do not believe the comment accurately reflects the consequences of our past action. Medicine did stay in its bed, relative to the need for health care delivery reform, while others aggressively got out of their bed and now look at the jam we are in today. If we had risen from our comfortable bed and aggressively sought medical care delivery reform and cost containment, we very likely could have avoided many of the major confrontations with which we are currently faced.

Organized medicine during the past one to two years has undertaken a tremendous task, in the face of very negative societal and governmental attitude, of assessing our current medical care delivery model and analyzing the recommended health care reform models of a variety of plans. Medicine now recognizes the need for significant health care delivery reforms, and has built a foundation of principles upon which we can formulate an effective health care delivery plan for the nation with adaptations for the respective states. These principles will require major modification of our existing medical care delivery systems, education and adaptation of physicians to those systems, and acceptance of cost containment methods. However, these principles do not require capitulation to the ill conceived concepts of others who would like to relegate the medical profession to a submissive group of subordinates to government and the managed health care industry.

Frederick F. Paustian, M.D.

Let us take a look at these principles and my perceptions as to where we should position ourselves. I shall greatly appreciate your comments in subsequent discussions as to alternative viewpoints.

Universal Health Care Insurance coverage is a laudable and highly desirable goal so as to obtain at least a satisfactory standard of health care for all citizens of this country. However, it does not have to be solely government owned and issued. For the population with income above a reasonable poverty level, it can be competitively planned and marketed by private industry under appropriate policies and regulations. Comparable health care insurance for the indigent, on the other hand, is the responsibility of society as a whole and, therefore, should be planned and managed by government.

Uniform Access to Health Care beyond the consideration of cost, which is at least reduced as a barrier by universal insurance coverage, is a far different problem. Cultural diversity and geographic location are two factors which prevent uniform access to desired health care for each citizen. A major effort must be extended to identify and strategically locate heath care centers throughout each state with associated transportation systems to at least physically facilitate access to needed care. A physician in every town with a population of at least 1000 is no longer feasible nor can such a ratio be justified.

It is now evident that Freedom of Choice must encompass multiple categories of decisions by individuals. Initially, the concept of freedom of choice related to the selection of a physician by a patient. Now it has become a matter of patient selection of a medical care delivery company, a medical delivery system plan, followed by selection of a physician who is contracted with the company and the plan. Futhermore, there is a problem of freedom of choice of the physician to contract with the company and a medical care delivery plan based on meeting certain company selection criteria. And, then there are the problems of de-selection of physicians as determined by plan management and the rights of patients to select out of plan physicians based on their medical care need. If is my contention that we must take a very strong positive position on the freedom of choice of physicians by patients and freedom of choice by physicians to select the medical care delivery plan with which they wish to contract and that de-selection of physicians from plans can only occur under the circumstance of due process based on specific publicized criteria. In addition, when patients have the perceived need for out-of-plan physician health care, they should be able to select such a physician service under plan coverage with only a modest increase in cost.

Uniform Basic Health Care Benefits are a must for the people of this country but coverage for medical services beyond basic health care must be dependent on each state's and individual citizen's economic circumstances. The individual who has the need for health care beyond that covered by the plan should have the right to seek such care. There should not be a marked financial or other penalty against citizens for seeking to obtain health care from legitimate sources beyond that which is covered by their respective plan. There must be guarantees within any health care plan delivery system which protects the physician-patient relationship and provides for a sense of health care security on the part of the patient.

Health Care Reform Financing is obviously a huge problem which should not be the sole responsibility of any single resource such as employers.

A pluralistic financing system involving employers, government, and individuals which requires health care insurance for every citizen is much more reasonable and realistic. The burden of health care costs cannot be afforded by any single segment of our economy including government. Employers should provide health care insurance under the circumstances of negotiated contracts with employees. Individuals should have the right to utilize a variety of methods to finance their own health care with similar tax write offs to those which are accorded employers. The establishment of medical services accounts, or so-called medical IRA's, warrants strong consideration as a unique method for individuals to provide for their own health care coverage. All of us as citizens of our respective states and the United States have an obligation through government to provide for the health care coverage of that unfortunate segment of our population who, for a variety of reasons, are unable to pay for their own health care insurance. The financial burden for the provision of health care for the indigent is a societal responsibility and not that of any one category of our population such as providers of health care. In very way we must be alert to the very popular legislative actions which in one way or another levy a provider tax against those who are responsible for the delivery of health care. Such potential actions must be defeated before they are ever allowed to be implemented.

In any plan of health care delivery reform there must be included significant Malpractice Reform. The cost of malpractice insurance premiums represents only a small fraction of the total cost of health care. However, the defensive practices of physicians, so as to avoid malpractice litigation, contributes in a large manner to the total cost of medical care services. It is very important to reduce the cost of defensive medicine but at the same time there must be protection for physicians for not performing every diagnostic test and then being accused of negligence.

The establishment of and compliance with Practice Parameters is one approach which

might be used to afford such protection. Malpractice insurance costs conceivably can be significantly reduced by systems of alternative dispute resolution, limits on plaintiff attorney fees, and capping non-economic damage. The most important factor, however, remains that of protection of physicians against litigation through the establishment of and compliance with appropriate practice parameters.

Hand in hand with the development of practice parameters is the necessity for Uniform Quality Standards of Health Care. The setting of such standards must be the responsibility of medical care professionals as opposed to the establishment and implementation of standards by economists and other non-health professionals. Quality standards determination, however, cannot be the sole prerogative of physicians and appropriately should include the consumers of health care, that is the patient, so as to provide proper balance.

Cost Containment relative to medical care services is a recognized must by everyone if our economy is to remain balanced and stable. The application of so-called spending caps and global budgets does not benefit patients, let alone physicians, and certainly does not permit a balanced economy. The consequences of such methods of economic control results in depriving the delivery of health care to those in need and is, therefore, unacceptable. As Dr. Kenneth Shine of the Institute of Medicine stated, total health care costs are a consequence of volume times price. Therefore, the only ways by which cost containment can be obtained is through reduction in the volume of health care services and/or a reduction in price. Physicians have already accepted and absorbed a reduction in price as is evident by the decrease in physician income by approximately 30% when comparing doctors income from the year 1991 with that of 1993. To further reduce physician income will result in repression of the profession and a shifting of potential health care providers to more attractive fields of endeavor. Therefore, the focus must be on volume. No one desires to deprive patients of necessary medical services by any system of rationing despite the pragmatic aspects of such a method.

A major method by which volume can be reduced is through Behavior Modification of our citizens as regards those behaviors which are knowingly detrimental to health. The obvious factors include smoking, alcohol, drugs, obesity, sexual promiscuity, and violence. We cannot expect to have immediate returns on behavior modification. It is a very slow education based process as exemplified by the public's very gradual acceptance of the untoward effects of smoking, the benefits of which were not realized for more than 25 years. It is the responsibility of physicians together with all education systems to bring about a change in behavior of our population which will reduce health care volume and ultimately cost. Through education we must inculcate the concept that society as a whole as well each individual must take responsibility for their state of health through disease prevention and health promotion.

A large concern regarding health care delivery reform relates to legislation and bureaucratic policy which deprives physicians of a so-called level playing field in negotiating health delivery contracts but also playing a major role in contributing to the development of regulations and policy which pertain to both health care delivery as well as health care itself. We in medicine must recognize the positions of others in the development of our new system of health care delivery but we cannot accept a minor participation status. In every way, we as physicians as well as members of organized medicine, must identify ourselves as the conscience of health care reform in order that our patients do not suffer as a result of very short-sighted, so called cost containment measures.

It is upon these ten principles involving health care reform that we must position ourselves strategically in order that the United States may carry forward into the next century the finest health care the world has ever known. Medicine must have an understanding of the needs of society, industry, and government. No longer can medicine pursue its own course in the advancement of medical science or the delivery of health care. We must be adaptable but that does not mean that we must capitulate to forces which are detrimental to the care of our patients.

Thank you!

GUEST EDITORIAL

It's All In Your Head

RONALD L. ASHER, M.D.
North Platte, NE

It's all in your head. Some of my patients tell me they have heard this. Sadly, I have said this myself. In my office schedule only a third have simple organic problems. Twenty per cent have pure "head" problems, such as "I've checked out all the books in the library and I have one of the following eight diseases". The remainder have a mixture of physical illnesses complicated by anxiety or social problems. All this is well known to primary care doctors. The problem created by "head" disorders is well known also - too much testing, too many medicines, and too much doctor shopping. A common statement is that 10% of the patients produce 90% of the headaches. Beyond the excess demand for resources is the fact that providing care is often less rewarding and certainly less invigorating. After all, there are very few cures in "head" medicine.

If a new paradigm for health care is being created, how should this group of "head" cases be cared for? Perhaps a new highly paid, highly revered speciality is needed. It could be called Cephology. The skills needed are already defined. There is a need for a strong knowledge of pathophysiology, utility of testing, and management of resources. The biggest trick would be the ability to convert this group from the dump category to that of a highly prized referral. The American Society of Cephologists would contain respected, articulate, and influential physicians. No doubt there would soon be an advocacy group - The American Cepholac Foundation - to recruit volunteers, organize fund raisers, and influence funding for research and grants. Soon hospitals will create Cephology centers in order to capture market share. Cephology may even develop its own diagnosis codes and DRGs.

Well, perhaps there is a another way. The special skills of primary care could be used to advantage. To do this, primary care does need to be rewarded appropriately for the time and effort needed to know the patient personally and for the skills needed to differentiate organic from psychophysiologic problems. These skills ought to be as well compensated and respected as many technical services. Research is needed to find the best strategies.

This is a special group of people with special problems. Their long term health and well-being depends on the skill and compassion of the medical team, both to discover the best approaches and to avoid excessive and dangerous interventions.

"Head" patients will continue to be with us and will continue to require an inordinate amount of resources. They represent a significant percentage of the patient population. Their best resource is their primary care doctors who needs to be recognized and rewarded for the very complex and difficult job they do.

GUEST EDITORIAL

Combatting Breast Cancer: The Roles of Public Health and the Clinician

MARK B. HORTON, M.D., M.S.P.H.

At least one in nine women will be diagnosed with breast cancer during her lifetime. This fact has great import for those of us involved in public health and health care in Nebraska. It is our collective responsibility to ensure that the women of Nebraska have available to them the latest technologies and therapies that allow for early detection and aggressive treatment to minimize morbidity and mortality from this dreaded disease.

While significant advances have been made recently in the understanding of the etiology and in the treatment of breast cancer, it is clear that of the interventions available to us today, routine breast exam and mammography for women 50 to 75 years of age offers the greatest opportunity to impact mortality from breast cancer. It is estimated that mortality can be reduced at least 30% by early detection and aggressive follow-up.

The report of Rettig, et al., in this month's Nebraska Medical Journal, indicated that most women in the age category at highest risk in Nebraska are not being regularly screened. The report also provides us with important information on where we need to concentrate our efforts to accomplish more universal screening. Public health efforts need to target individuals with advanced age, rural residents, those living in relative poverty, and the less well-educated.

The report also highlights the fact that two-thirds of the Nebraska women not screened had seen a physician for a routine check-up in the year prior to the survey, and that lack of a physician's recommendation is one of the most prominent reasons why women do not get mammograms. The report refers to a recent survey documenting factors that deter physicians from adhering to recommended screening guidelines, including cost, accessibility, efficacy, and fear of radiation effects. Finally, the report refers to a study demonstrating the efficacy of an office-based computer-generated reminder letter in assisting physicians in assuring timely follow-up and management of abnormal screening mammograms.

Using this report, we can lay out a comprehensive agenda to accomplish more universal utilization of breast exam and mammography for the early detection of breast cancer. First, we need to target our educational efforts on, and remove barriers from, the elderly, rural residents, the poor, and the less well-educated. Second, we need to work to solve cost and access issues while we allay fears of radiation risk and misperceptions regarding efficacy among practicing physicians as well as the general public.

The public health and medical communities need to work in close partnership to take on this agenda. Public health role is to address population-based aspects: targeted education efforts, identification of barriers to access, and resources to address cost. The "Every Woman Matters" program is a federal - and state - funded public health initiative with broad community support and participation to address these public health responsibilities.

In the end, however, as stated in the article by Rettig, et al., "the degree to which screening mammograms can effectively reduce breast cancer mortality will continue to rely primarily on their acceptance and active recommendation by physicians." Public health efforts cannot succeed without the support and participation of practicing physicians.

I join with the Nebraska Medical Journal and the Nebraska Medical Association in their efforts to alert the medical community to the serious under-utilization of mammography and clinical breast exam for the early detection of breast cancer. And I urge all clinicians to rededicate themselves to ensuring that every woman has access to, and takes advantage of, this life-saving clinical preventive service. Women 50 to 75 years of age should be scheduled for yearly check-up in the physician's office. At each visit, she should be reminded of the importance of breast self-examination, clinical breast exam, and mammograms. The technique of breast self-examination should be reviewed; and she should receive a clinical breast exam and a referral for a mammogram. Finally, abnormal findings in self breast exam, clinical exam, or mammography should be aggressively pursued. Computer-generated reminder letters will greatly assist the physician in this endeavor.

While we await further advances in our ability to diagnose and treat breast cancer, vigorous application of available effective public health and clinical interventions will have the greatest impact on breast cancer morbidity and mortality.

ORIGINAL ARTICLE

Breast Cancer Screening: Recent Trends In The Use Of Mammography In Nebraska

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INTRODUCTION

BETWEEN 1988 and 1992, 1,453 Nebraska women died from breast cancer, making it the most frequent cause of cancer deaths among Nebraska women during the period.[1] Since research into the etiology of breast cancer has not yet definitively determined how to prevent new cases from occurring, the widespread application of mammography for screening asymptomatic women remains the best method with which to reduce breast cancer mortality. Although the effectiveness of mammography as a screening tool has been repeatedly questioned, it is important to note that this controversy has focused on the value of mammography for screening women less than 50 years old. For women who are 50-74 years of age, however, the evidence is clear: regular screening by a combination of mammography and physical breast examination will significantly reduce breast cancer mortality.[2] Both the American Cancer Society and the National Cancer Institute recommend that women 50 years of age and over obtain a screening mammogram and clinical breast exam annually.[3]

The purpose of this article is threefold: 1) to report recent trends in the use of mammography among Nebraska women 50 years of age and older, 2) to examine how mammography use differs by certain demographic and socioeconomic factors, and 3) among women who have not had a mammogram within the past year, to determine how long it has been since their last visit to a physician for a routine medical check-up.

METHODS

The data presented here are from the 1988-1992 Nebraska Behavioral Risk Factor Surveys (BRFS). The Nebraska BRFS is a random digit-dial telephone survey of the state's adult population concerning a wide variety of health-related behaviors; the survey is conducted annually and currently interviews about 1,800 people per year. The BRFS was developed and is sponsored by the Centers for Disease Control and Prevention, and is conducted in 47 other states (and the District of Columbia) besides Nebraska. In Nebraska, the BRFS is conducted and supported by the Nebraska Department of Health's Division of Health Promotion/Education.

Women who participated in the 1988-1992 BRFS were asked whether they had ever had a mammogram, and if so, when they had had their last mammogram and whether it was done as part of a routine check-up, because of a breast problem, or because of a previous breast cancer. The same questions were asked regarding clinical breast exams, but only on the 1990-92 BRFS. All 1988-1992 BRFS participants were also asked how long it had been since their last routine check-up by a physician. The wording of these questions, along with the questions pertaining to demographic and socioeconomic factors, was identical in all five surveys.

Analyses were restricted to women 50 years of age and older. The results from individual years were used to analyze trends in the use of mammography. The results from the two most recent surveys (1991-1992) were combined to examine the use of mammography by demographic and socioeconomic factors, and to examine the time since last routine medical check-up among women who had not had a mammogram within the past year.[4] The data were weighted to reflect the age and racial composition of the state according to the 1990 U.S. Census, and also to reflect the probability of selection into the survey sample.

RESULTS

As shown in Figure 1, mammography use among Nebraska women 50 years of age and

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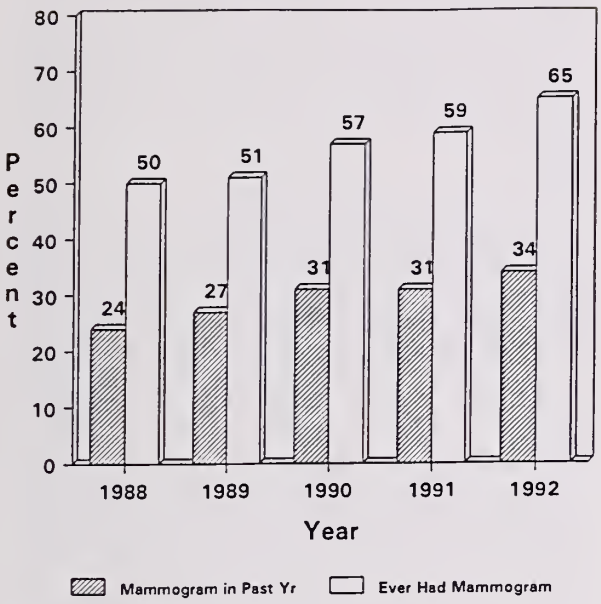
FIGURE 1
Trends in Mammography Use Among Women 50 Years of Age and Older.



Source: Nebraska BRFS, 1988-1992

older increased considerably from 1988 to 1992. The percentage of women who reported that they had ever had a mammogram increased from 50% in 1988 to 65% in 1992. Similarly, the percentage of women who had a mammogram within the past year also increased, from 24% in 1988 to 34% in 1992. During the same period, the percentage of women who reported that their last mammogram was done as part of a routine check-up increased moderately, from 77% to 85%. In spite of these positive trends, however, Nebraska ranked next to last in 1992 among the 48 states conducting the BRFS in terms of the percentage of women at least 50 years of age who had had a mammogram within the past year.[5]

Table 1 shows that the percentage of Nebraska women 50 years of age and older who have had a mammogram within the past year varies considerably by socioeconomic and demographic factors. Women 65 years of age and older were less likely to have had a mammogram within the past year than women 50-64 years of age, by a margin of 38% to 29%. Women with an annual household income of more than $35,000 were more than twice as likely to have had a mammogram within the past year than women with a household income of less than $15,000 per year (52% vs. 25%). Similarly, women with at least some college education were twice as likely to have had a mammogram within the past year than women who had not completed high school (47% vs. 23%). Urban residents (defined as anyone living in either Douglas, Lancaster, or Sarpy Counties) were more likely than rural residents (defined as anyone living outside of Douglas, Lancaster, or Sarpy Counties) to have had a mammogram within the past year, by a margin of 40% to 29%.

TABLE 1
Percentage of women >= 50 years of age who reported having had a mammogram within the past year.

	%
All	33
Age	
50-64	38
65+	29
Annual household income	
< $15,000	25
$15,000-$35,000	38
>$35,000	52
Education	
<high school graduate	23
high school graduate	34
>high school	47
County of residence*	
rural	29
urban	40

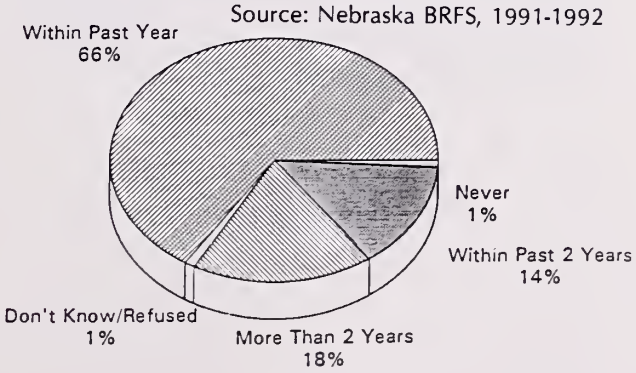
*Urban defined as residence in Douglas, Lancaster, and Sarpy Counties; rural defined as residence in all other counties.

SOURCE: Nebraska BRFS, 1991-1992

For Nebraska women 50 years of age and older who have not had a mammogram within the past year, Figure 2 shows how long it has been since their last visit to a physician for a routine medical check-up. Surprisingly, nearly two-thirds (66%) of the women who reported that they had not had a mammogram within the past year reported that they had seen a physician within the past year for a routine medical check-up.

FIGURE 2
Time since last routine check-up in women 50 and older who did not have mammogram within the past year.

Source: Nebraska BRFS, 1991-1992



and aggressiveness, and any delay in establishing a diagnosis or instituting appropriate treatment may have deleterious consequences for an individual patient. Using the traditional communication methods of written report and direct telephone contact, a Massachusetts General Hospital study revealed 16% incomplete evaluation at 3.5 months and 6% at 4.5 months after initial screening mammogram.[12] Similarly, a University of California-San Francisco (UCSF) study found 11.1% of patients with abnormal screening mammograms lost to follow-up after six months.[13] However, using a computerized patient database management system which generated reminder letters, a subsequent UCSF study found less than 1% with abnormal screening mammograms lost to follow-up after six months.[13] Given these findings, screening facilities in Nebraska should consider conducting their own follow-up studies and also consider implementation of a computerized patient management system.

SUMMARY

Although the efficacy of screening mammography has been surrounded in controversy of late, the evidence that it can reduce breast cancer mortality among women 50-74 years of age is extremely sound. In Nebraska, data from the state's Behavioral Risk Factor Survey show, that during the years 1988 to 1992, the percentage of women age 50 years and older who had ever had a mammogram rose from 50% to 65%, while the percentage of women of the same age who had had a mammogram within the past year rose from 24% to 34%. Nebraska BRFS data also show that the percentage of women 50 years of age and older who have had a mammogram within the past year varies considerably by age, income, education, and county of residence. Among women who have not had a mammogram within the past year, 66% reported that they had seen a physician within the past year for a routine check-up. Prompt and appropriate follow-up of abnormal findings by both physicians and health-care organizations is also essential to ensure the maximum benefit of screening mammography.

ACKNOWLEDGMENTS

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COMMENT

As a radiologist in a group that reads thousands of mammograms a year, I oftentimes tongue in cheek ask myself (usually at 5 o'clock on Friday afternoon) how there could possibly be any more women who need a mammogram. The truth of the matter is that there are literally thousands of women in Nebraska who should be undergoing mammography, regardless of whose recommendations one follows. The data presented by Rettig et. al. has been a source of mystery and concern since its initial collection in the late 1980's. Nebraska has always been in the bottom third in mammograms and it was rumored that this aided in the award of the CDC grant and creation of the "Every Women Matters" Program.

And now Nebraska is next to last in terms of women over 50 who had a mammogram within the past year. My heartfelt concern is that some of these women may have been symptomatic or in a high risk group. This survey grouped all reasons for mammography, and from our personal hospital mammography QA, I know that some women with the diagnosis of breast cancer have never had a mammogram. Even if a palpable mass is present there may be a synchronous nonpalpable or a contralateral breast cancer present.

The reasons for Nebraska's low rate is perplexing and undoubtedly due to a myraid of reasons. The District of Columbia had the highest rate of women getting mammograms in the past year (60.2%) but I doubt crime and the number of politicians had any bearing. All of our neighboring states were between 41-51% yearly followup after age 50, with South Dakota at 41% and Colorado at 51%. Seven states ranked with Nebraska below 40%.

I find that many care providers lack a practical algorithm for breast problems. And many are uncertain of any screening guidelines. First of all I would find a set of guidelines that your professional society has endorsed, or that you have researched, and use them for screening purposes in women who have a negative breast exam. I espouse the screening recommendations put forth by the American Cancer Society and American College of Radiology. A baseline mammogram between ages 35-40, biennial screening between 40-50, and annual screening after age 50. This will raise the ire of many who feel that screening should not begin until age 50, but I feel we are still in the data collecting stage of a humbling cancer and the technical improvements of mammography equipment improve yearly thereby allowing better quality, less radiation and potentially an earlier diagnosis of some cancer types. It is not unethical nor malpractice to perform mammography before age 50.

Once you have decided upon a screening protocol, then predetermine what you will do for women in the 20-30, 30-40, and over 50 year age groups who come to you with a breast problem. Consulting with your area surgeon or radiologist is recommended. Again mammography, coupled with ultrasound and biopsy (which can be either open, stereotactic, or by ultrasound) will assist you in solving the problem. It will also aid you in any litigation that comes down the dusty road in later years. And yes, mammography is useful in women with implants, and no, they will not rupture during breast compression.

The good news is that when you are so low in the ratings you can only go one way. Nebraska physicians will certainly rise to the challenge of improving our mammography rates where appropriate. By the way, who was last? Mississippi.

Joe Stavas, M.D.

ORIGINAL ARTICLE

The Evaluation, Indications, and Contraindictions of Selective Neck Dissections

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THE initial spread of squamous cell carcinoma of the head and neck is usually to the cervical lymph nodes. Studies have shown that survival decreases significantly and consistently as nodes progress from negative to occult to palpable.[1] Shah in a retrospective study of 352 patients found the five year survival to drop from 69%-39%-28% to 0% for patients with necks staged N0, N1, N2, and N3, respectively.[2] (Tables 1 and 2[3])

TABLE 1

NX	Minimum requirements to assess the regional nodes cannot be met.
N0	No clinically positive node
N1	Single clinically positive homolateral node 3 cm or less in diameter
N2A	Single clinically positive homolateral node more than 3 cm but not more than 6 cm in diameter
N2B	Multiple clinically positive homolateral nodes, none more than 6 cm in diameter
N2C	Bilateral clinically positive nodes (in this situation, each side of the neck should be staged separately; that is, N2C: right, N2A: left, N1) Contralateral clinically positive node(s) only
N3	Clinically positive homolateral node(s), one more than 6 cm in diameter

Vikram from Memorial Sloan-Kettering Cancer Center studied relapse rates above the clavicles and distant metastasis in a select group of patients.[4] All patients were advanced stage (III or IV) and had unfavorable pathologic findings: unsatisfactory surgical margins (grossly, less than 5 mm and/or microscopically positive), cervical metastasis at multiple levels, or both. Historical controls treated by surgery alone showed a relapse rate above the clavicles of more than 70% within two years. In the series of patients described above the incidence of relapse above the clavicles was 15% when postoperative radiation therapy was added.[3] Certainly treatment of some form is indicated. Most clinicians would also agree that palpable neck disease is best treated by surgical dissection. The primary areas of controversy are how do we approach the clinically negative neck, and when is combined treatment with surgery and radiation therapy indicated.

Although controversial, many clinicians believe treatment of the N0 neck can usually be accomplished with either surgery or radiation. Medina and Byers reviewed 389 patients that had supraomohyoid neck dissections done at (M.D. Anderson Cancer Center).[5] They found a regional recurrence rate of 5% in histologically negative necks, 10% in necks with one positive node, and 24% in necks with multiple histologically positive nodes or nodes with extracapsular spread (ECS). The rate of recurrence could be reduced to 15% in those patients in the later group by adding postoperative radiation therapy, but had no effect on the survival rates of patients with histologically negative nodes or those with one positive node only. We believe that dissection of the neck with a >20% statistical chance of harboring occult neck disease allows the selective use of radiation based on the histologic evaluation of the specimen. This potentially spares the patient the lifelong sequelae of radiation with the minimal morbidity of a selective modified neck dissection. This concept will be developed later.

The current recommendations for postoperative radiation therapy based on the histology of the dissected neck specimen are:

1. More than one positive lymph node. Two nodes in the anatomic subsite is not an absolute indication for radiation therapy if all other factors are negative.
2. A lymph node with extracapsular spread.

In spite of this data most clinicians agree that the single most consequential cause of failure in properly treated head and neck cancer is the inability to control the neck.[6]

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This leaves the head and neck oncologist with several challenges; to better treat the metastatic disease in the neck, to detect, treat or prevent distant metastasis, and to detect, treat or prevent second primaries. Close follow-up and vigorous antismoking counseling must be a matter of routine.

Several points of anatomy and physiology of the lymphatics should be reviewed. Anatomic study of the lymphatics of the head and neck reveals tiny intercalated nodes that occur anywhere along a lymph channel. Recurrences can theoretically occur anywhere along these channels and radiation therapy proposes to sterilize these channels. In actual clinical practice recurrences along these channels without prior obstruction is very rare. Obstruction has the effect of stagnating flow and possibly contributing to recurrence and rerouting lymphatic flow thus causing less predictable lymphatic spread of tumor cells. Radiation therapy causes partial obstruction that is dose dependent. Tumor replacement of the node itself causes partial or complete obstruction of lymphatic flow. Surgery produces complete obstruction. The first attempt to cure the patients neck is certainly the most successful as variable lymphatic spread is seen after obstruction that is secondary to surgery, radiation, or tumor replacement. When cervical lymphangiography is done after radical neck dissection, a persistent ipsilateral obstruction is observed. Subcutaneous diversion of the lymph flow is seen toward the submaxillary area with submental shunting to the contralateral lymph nodes. Further obstruction of the lymphatic pathway occurs with irradiation or a bilateral neck dissection. It is of clinical importance to irradiate as little of the skin as possible in patients undergoing neck dissection plus radiation therapy in order to preserve the dermal lymphatics and prevent lymphedema.

There are 150-350 lymph nodes above the clavicles. The most important chain to the head and neck oncologist is the internal jugular chain which stretches from the base of the skull to the base of the neck. Jugulodigastric nodes are described as lying deep to the sternocleidomastoid and posterior belly of digastric muscles which form a junction between the internal jugular nodes and the spinal accessory chains. They represent an important but difficult to detect group of nodes.

The internal jugular nodes are divided into upper, middle, and lower groups. The upper nodes lie anterior or lateral to the internal jugular vein and may be palpated anterior or deep to the sternocleidomastoid muscle. Virtually all head and neck malignancies spread to these nodes either primarily or secondarily. The middle nodes are deep to the sternocleidomastoid muscle at the level of the thyroid notch and cricoid cartilage. The lower nodes are an inconstant group that lie close to the trachea.

The posterior jugular nodes (spinal accessory) follow the course of the spinal accessory nerve and blends with the internal jugular chain superiorly. These upper nodes are sometimes called junctional nodes. The inferior nodes of the chain diverge posteriorly and are continuous with the supraclavicular nodes. The supraclavicular nodes are located at the upper border of the clavicle. They receive lymph from the head and neck, ipsilateral upper extremity, breast, thorax, and abdomen.

The submandibular nodes drain the lips, floor of month, buccal mucosa, upper and lower gingiva, nasal vestibule, skin of the anterior face, tongue, palate, submandibular and sublingual glands. The submental nodes are external to the mylohyoid muscle. They receive lymph from the lip, chin, and cheeks and some floor of mouth, anterior lower gingiva and tip of tongue. Lymph from here drains to the submandibular and subdigastric nodes.

Posteriorly the occipital nodes are identified. They drain the posterior scalp and skin from the upper neck. The preauricular nodes are located anterior to the tragus and superficial to the temporalis fascia. They drain the frontal scalp, temple, nose, eyelids, pinna, external auditory canal, malar area and the eustachian tube. The delphian node is palpated in the midline and receives prelaryngeal lymph from the thyroid and larynx.

Knowledge of the lymph node spread is paramount in selective neck dissections. Radical neck dissection as described by Crile[7] has been the mainstay of treatment for the patient with palpable metastasis. The operation is effective in removing metastasis in the neck but is associated with considerable morbidity. It is difficult to justify the use of the radical neck dissection in patients with bilateral disease or in necks clinically negative but at high risk. Bilateral neck dissection is associated with an increased mortality and morbidity.[8] Because of these problems, Ballantyne and others at the

M.D. Anderson Cancer Center began experimenting with modification of the classic radical neck dissection to preserve the spinal accessory nerve, sternocleidomastoid muscle, and internal jugular vein.[9] Dissections that remove all node groups removed in the radical neck dissection (RND), but preserves these three structures will be referred to as the modified neck dissection (MND). Shortly thereafter radiation therapy was found to sterilize microscopic deposits of cancer in the neck and was added to the treatment regime. Lineman studied 347 patients that had radical neck dissections and compared them to 98 patients that underwent modified neck dissection with sparing of the spinal accessory nerve, sternocleidomastoid muscle and the internal jugular vein if possible.[10] Regional recurrence rates compared favorably for stages N0, N1, and N2; with RND rates 14%, 15%, and 26%, and MND rates 0%, 16%, 25%, respectively. Radiation therapy was given 68% in the RND group and 50% in the MND group. Distant metastasis developed in 10% and 8% in the RND and MND groups, respectively. Further studies have defined the indications for postoperative radiation therapy and have been discussed and outlined previously.

The rationale for using the modified neck dissection include the following:

1. All fascia enveloping spaces are wholly elevated and excised in both disscetions.
2. Sternocleidomastoid muscle and internal jugular vein lie outside the spaces.
3. Modern surgery fosters functional preservation.
4. Lymph nodes lie in close proximity to the fascia.
5. Some structures are left intact for functional reasons in the RND; carotid arteries, vagus, phrenic, hypoglossal, and lingual nerves, and supraclavicular branches of the brachial plexus.
6. Nodes are never intimately associated with vessels or muscles unless direct penetration of the lymph node capsule has occurred.
7. MND remove all lymph bearing tissue removed by the RND.
8. Recurrence rates in the neck are similar for RND and MND for N0 and N1 necks.
9. The MND is an important staging tool for N0 and N1 necks to determine the need for post operative radiation therapy.
10. The MND is therapeutic for N0 and N1 necks without extracapsular spread (ECS) or multiple positive nodes.
11. The MND provides an alternative to radiation therapy.
12. The MND avoids unnecessary morbidity of dropped shoulder, skeletal pain, limitations of neck and limb motion, and widespread cutaneous anesthesia attendant with the RND.
13. The MND can be done bilaterally.
14. The long-term survival of patients is not adversely effected in patients treated with the MND instead of the RND.
15. The MND maintains protection of the carotid artery.
16. Tumors drain in predictable patterns and only nodes at risk need to be removed.

The indications for using the MND include the following:

1. Clinically negative necks with a high probability of occult metastasis (> 20%)
2. N1 mobile nodes
3. Bilateral neck dissections
4. Necks staged N2c by virtue of bilateral or contralateral N1 disease.

After the safety and indications were established for modified neck dissections the stage was set for the development of the selective neck dissection, a dissection that removes only the node groups at risk. Byers[11] reviewed 1,372 MND done in 967 patients at M.D. Anderson Cancer Center from the years 1970 to 1980. He not only confirmed the effectiveness of treating N0, and N1 disease with MND, but outlined the criteria for postoperative radiation therapy. In addition, it was noted that predictable patterns of nodal involvement could be established based on the site and stage of the primary lesion. From this data the concept of selective neck dissection was developed. Anterior, supraomohyoid, suprahyoid, and posterolateral neck dissections, among others, were developed.

The safety, indications, and contraindications have been tested and confirmed for each of the dissections discussed.[4,10,11,13] The following is an outline of the most commonly used selective neck disssections with their indications,

contraindications, and node groups removed.

1. Posterolateral Neck Dissection[12]
   A. Node groups removed
      1. Retroauricular
      2. Suboccipital (superficial and deep)
      3. Upper posterior cervical (spinal accessory)
      4. Upper jugular chain
   B. Indications:
      Scalp lesions posterior to a coronal plane through the external auditory canal, (Squamous cell carcinoma and Melanoma), that have a >20% probability of occult metastasis. This includes lesions of the occipital area and nape of neck.
   C. Other factors:
      1. Can be done bilaterally.
      2. Flaps are designed so that extension to a RND, MND, or parotidectomy is possible.
      3. Spinal accessary nerve is usually spared.
      4. Most surgeons retract the splenius capitis anteriorly rather than resecting the muscle.

II. Supraomohyoid Neck Dissection[4,12]
   A. Node groups removed
      1. Submental and submandibular
      2. Upper jugular and upper posterior lymph nodes.
      3. All lymph node bearing tissue anterior to the cutaneous branches of the cervical plexus and above omohyoid muscle.
      4. May need to extend dissection to area posterior to the cervical plexus or superior and posterior to the spinal accessory nerve.
   B. Indications
      1. Large T2, T3, T4 cancers of the floor mouth, oral tongue, alveolar ridge, buccal mucosa, retromolar trigone and faucial arch with N0 necks. (Necks with > 20% chance of harboring occult metastasis).
      2. N1 necks with metastasis located at first echelon nodes.
      3. CT scan suggesting metastasis.
      4. Difficult to evaluate necks.
      5. Necks that must be entered surgically for ablation of the primary lesion.
      6. Inability to maintain postoperative follow up.
      7. Inability to undergo radiation therapy.
      8. We now recommend dissection for all oral tongue cancers except very superficial T1 cancers.[12]
   C. Other factors
      1. Can be done bilaterally
      2. Allows selective use of radiation therapy.
      3. Adequate treatment for necks without multiple nodes or nodes with ECS.
      4. Adequate treatment for certain salivary gland malignancies and melanomas.

III. Anterior neck dissection
   A. Node groups removed
      1. Upper, middle, and lower jugular nodes
      2. Widefield laryngectomy is simply a total laryngectomy and bilateral anterior neck dissections.
   B. Indications - clinically negative nodes and:
      1. Widefield laryngectomy
      2. Supraglottic laryngectomy
   C. Other factors
      1. Can be done bilaterally
      2. Allows selective use of radiation therapy

In summary, we believe the use of modified and selective neck dissections is well established. They are also very beneficial when properly executed and used for the correct indications. Care must be taken to not "stretch" the indications, however, and we never hesitate to use the radical neck dissection when indicted.

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COMMENTS

Dr. Lydiatt, et al have simplified the evaluation and indications of selective modified neck dissection for carcinoma of head and neck in this article. RND and MND have been shown to have same recurrence and survival rate. MND, obviously avoids unnecessary morbidity of dropped shoulder, cutaneous anesthesia and skeletal pain and maintains protection of the carotid artery. Indications of various types of MND are described fully well and it has been stressed that MND preserves the spinal accessary nerve, sternocleidomastoid muscle and internal jugular vein. Properly planned and executed, MND is beneficial if performed for correct indication.

Pradip K. Mistry, M.D.

ORIGINAL ARTICLE

Thoracic Outlet Syndrome: A Misunderstood And Potentially Devastating Problem

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THORACIC outlet compression syndrome encompasses several different abnormalities, with the vast majority (97%), related to the nerves of the brachial plexus. The remainder are lumped into arterial and venous problems. The thrust of this discussion is to better understand this diagnostic dilemma and to analyze the neurological and vascular issues associated with this problem and the best means to treat these entities. The first operation in the modern literature for this problem was described by Coote[1] in 1861 in London. Progress remained stagnant for many years as supraclavicular removal of the first rib was the norm, until the late 1920's, when Adson[2] described division of the scalene anticus muscle as the method of choice to decompress the brachial plexus. Several years passed before Clagett[3] reported the removal of the first rib by the transaxillary approach. Roos[4] in the mid-1970's, summarized the multiple congenital muscle and soft tissue anomalies associated with this problem. He is considered one of the leading world experts today with respect to thoracic outlet syndrome.

In our test oriented medical environment, thoracic outlet syndrome has yet to effect a study that will diagnose this problem with a high degree of accuracy. This is partly the reason why many practitioners question the validity of this clinical entity. Nerve conduction studies, electromyography, and somatosensory evoked potentials[5] have all been utilized to aid in the diagnosis, without high levels of success. These tests, however, play a significant role in evaluating this entity as a means of excluding other diagnoses as a cause of the patient's pain and numbness.

Currently, the diagnosis of neurological thoracic outlet syndrome is based on a thorough history and physical examination focusing attention to the upper extremity nerves and musculoskeletal system. The "Adson Maneuver", which is obliteration of affected radial pulse with abduction and external rotation of the arm, is a nice test, but it plays no role in the diagnosis of this problem, since 50% of the normal population are found to have a positive test, but without symptoms. The three minute elevated arm stress test as described by Roos[4] rapidly reproduces the patient's symptom complex in nearly all people felt to have this diagnosis. The supraclavicular brachial plexus is frequently tender to palpation and percussion. Historically, these patients have often experienced antecedent trauma to the neck and shoulder girdle area or perform a repetitive activity that leads to symptoms of pain in the neck and shoulder area as well as numbness radiating down the arm in the ulnar nerve distribution. Simple tasks, such as driving the car with the arms elevated on the steering wheel, combing or drying one's hair, as well as elevating the arms to shoulder level will rapidly bring on this symptom complex. These symptoms just described are known to occur with lower plexus (C8 ant T1) thoracic outlet syndrome.

If the upper plexus (C5, C6, and C7) nerves are involved the symptoms appear much different and the treatment is likewise not the same. These patients complain of pain in the anterior and lateral portions of the neck as well as behind the sternocleidomastoid muscle. Pain frequently radiates to the jaw and ear and also spreads to the scapula and over the upper anterior chest area. The physical exam reveals extreme tenderness over the trunk (C5) of the brachial plexus especially when the neck is tilted away from the examiner.

As alluded to earlier, surgical treatment of these disorders is dependent upon the portion of the brachial plexus involved. The lower plexus problem is best treated surgically with transaxillary removal of the first rib along with resection of adjacent fibrous bands and muscu-

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lar anomalies. Anterior scalenectomy, via a supraclavicular approach decompresses the upper plexus and allows relief of this symptom complex. Some authors such as Sanders[6] feel that scalenectomy plays a significant role in treating patients with lower plexus symptomatology.

Arterial and venous complications of thoracic outlet syndrome are frequently more obvious and impressive than the neurological counterpart. Patients with "effort thrombosis" or young people with subclavian-axillary vein thrombosis should be evaluated at once by venous duplex scanning or upper extremity venography to determine the status of the affected vein as well as the opposite vein. If the onset of symptoms is recent, (within 72-96 hours), the use of thrombolytic agents infused directly into the clot is indicated. If complete clot lysis occurs, one should re-evaluate the affected vein venographically in both the neutral and abducted-externally rotated position. If substantial compression of the vein occurs in the stressed position a first rib resection would likely benefit this patient.

Arterial complications occur more frequently with associated cervical ribs. The cervical rib will often fuse into the top of the first rib thereby causing compression of the subclavian artery when the arm is abducted. This may lead to post-stenotic dilatation of the artery as well as aneurysm formation. Mural thrombus can form in the wall of the aneurysm and distal embolization might also occur. Angiography is recommended in any patient with a prominent supraclavicular pulse or bruit in association with a cervical rib. Treatment depends upon the complexity of the problem at the time of the diagnosis, but could mean resection of the aneurysm with graft placement, complete removal of the cervical rib and anterior scalenectomy done through a combined supraclavicular and infraclavicular incision. This may at times necessitate removal of a portion of the clavicle. If distal thrombus is present as seen on the preliminary arteriogram attempts should be made to remove this.

Two cases are presented in detail to illustrate the severe vascular complications one may encounter.

CASE REPORTS

Case I. B. B. is a 42 year-old white female who presented with a two week history of sudden onset of discomfort in her right arm and hand. This would be made worse with trivial use of the right arm. She works as a bank employee and several times each day lifts 20 to 50 pound money bags at or above shoulder level onto shelves in the bank vault. Physical examination revealed normal pulses in the left arm, but absent brachial, radial and ulnar pulses on the right arm. X-ray of the chest and lower neck displayed complete cervical ribs bilaterally (Fig. 1). Arteriogram of the both subclavian arteries disclosed aneurysmal dilitation of the proximal left subclavian artery (Fig. 2) and a right subclavian artery aneurysm (Fig. 3) with a cutoff occlusion of the proximal brachial artery with distal reconstitution (Fig. 4). She underwent surgery and the above findings were confirmed as well as the presence of mural thrombus in the wall of the aneurysm. The aneurysm was resected and an interposition vein graft placed. She had complete removal of her cervical rib, anterior scalenectomy and thromboembolectomy of the occluded brachial artery. She did well from the surgery and a few weeks later underwent left cervical rib removal along with anterior scalenectomy. This case illustrates the most severe arterial complication that one may encounter when dealing with this problem.

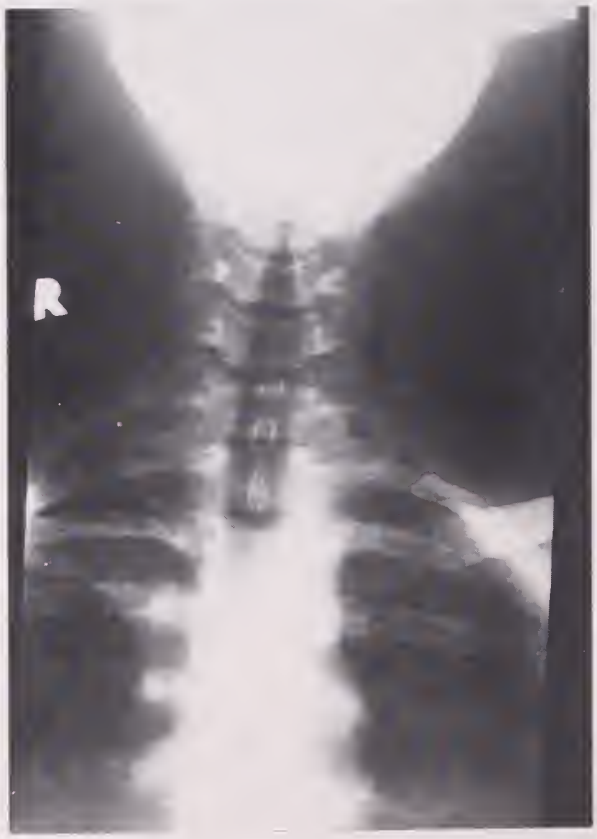

FIGURE 1
X-ray of the chest and lower neck revealing completely fused cervical ribs bilaterally.

FIGURE 2
Arteriogram of the left subclavian artery discloses aneurysmal dilitation of the proximal left subclavian artery.

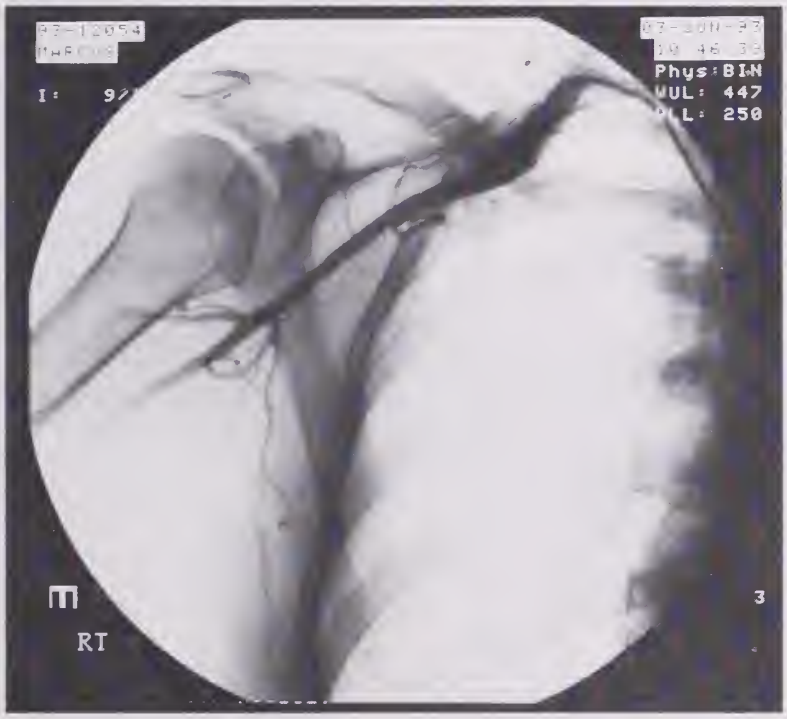

FIGURE 3
Right subclavian arteriogram shows an aneurysm of the right subclavian artery with occlusion of the proximal brachial artery.

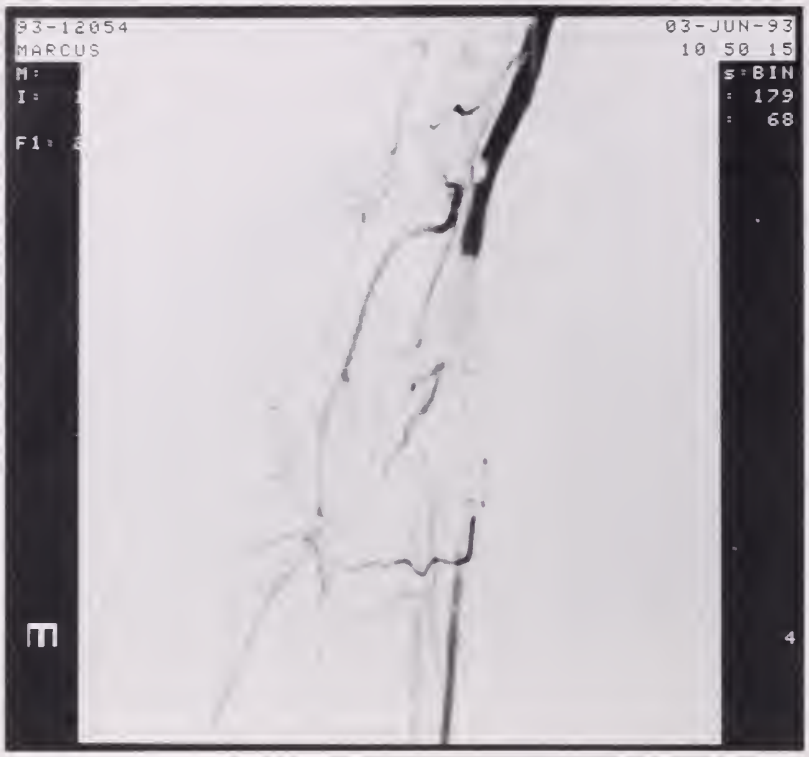

FIGURE 4
Arteriogram of the proximal right brachial artery which reveals occlusion and distal reconstitution of the brachial artery.

CASE II

C.M. is a 52 year-old white female who works in a convenience store. Much of her day is spent stocking shelves at or above shoulder level. She presented with a two day history of left arm pain and swelling. Venogram of the left arm (Fig. 5) was performed and revealed subclavian-axillary vein thrombosis. Urokinase was infused directly into the clot and at 24 hours complete clot lysis had occurred (Fig. 6). The venogram was also performed in the abducted and externally rotated position which shows obstuction to flow of blood at the level of the

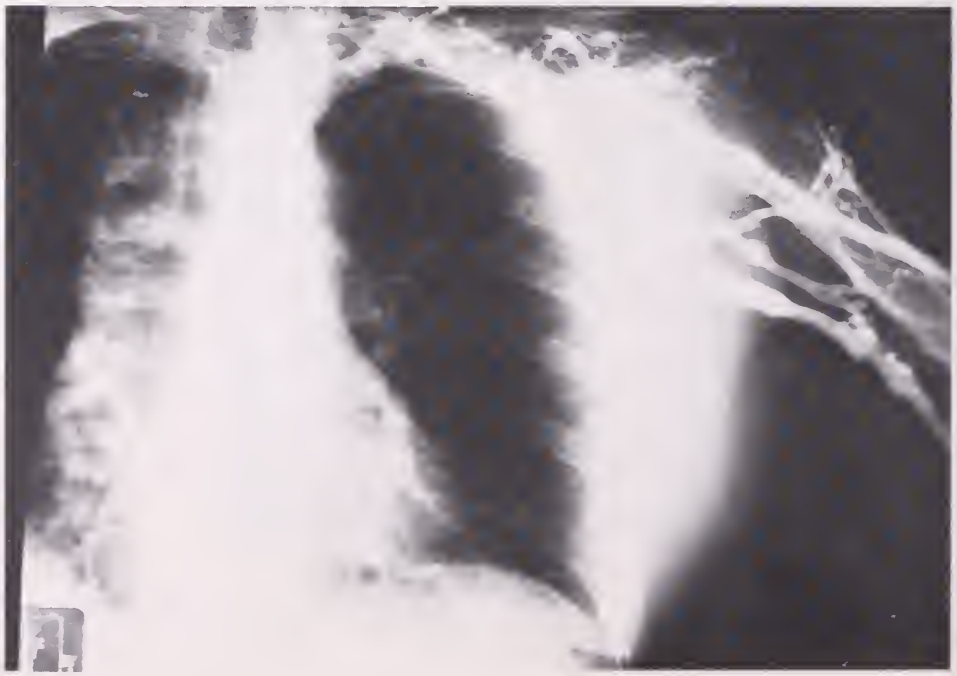

FIGURE 5
Venogram of the left arm which shows thrombosis of the subclavian axillary vein.

FIGURE 6
Venogram performed after 24 hours of Urokinase infusion showing complete lysis and patency of the left subclavian axillary vein.

FIGURE 7
Venogram of the left subclavian axillary vein after complete clot lysis in the abducted-externally rotated position. This shows obstruction to blood flow in this vein at the level of the clavicle. First rib resection rectified this problem.

left clavicle (Fig. 7). This patient underwent successful removal of her left first rib and continues to do well in follow-up.

These cases represent the severity with which thoracic outlet syndrome can present. They are also the more obvious problems with the most definitive diagnostic studies and have outcomes that are far more predictable than their neurological counterparts.

In cases of mild neurologic thoracic outlet syndrome, physical therapy, warm moist packs to the affected area and a dedicated exercise program will keep the vast majority of these patients away from the operating room. Nearly 80% of all patients that I see will never need surgery and rightfully so, but the other 20% with severe and incapacitating symptoms who undergo either a first rib resection or anterior

scalenectomy will do so with predictably good to excellent results 75 to 80% of the time.

I have performed 40 such operations over the past six years. Seventeen (17) patients (43%) had an excellent result with all symptoms gone. Another thirteen (13) patients (32%) experienced a very good result with only minor discomfort. Thus three-fourths of this surgical group had an exceptional outcome. Six (6) more people had what I term a good result with some residual discomfort most often in the shoulder and neck areas, but with resolution of arm pain and numbness. Four (4) other patients (10%) had no improvement and I conclude had the wrong diagnosis made prior to surgery.

As one can see progress has been made over the past several years with respect to this entity. A well planned physical therapy and exercise program as well as careful evaluation and cautious surgical intervention can and does help those patients with this very difficult problem. Our concern for the future must be to improve our diagnostic methods along with dedicated therapy programs which together will equate to a higher percentage of excellent outcomes.

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ASK A LAWYER

1. When a couple who have minor children obtain a divorce, who has access to medical records and makes medical decisions for the children?

Nebraska law (§ 42-381, Neb. Rev. Stat. 1943, as amended) provides that regardless of who has custody, each parent continues to have full access to medical records unless the court orders to the contrary. In this regard it is best to ask to see a certified copy of the court order dissolving the marriage.

2. What about emergency situations and where the minor's status as determined by the court order is unknown?

Either parent may make emergency decisions affecting the health of safety of the child while the child is in the physical custody of that parent.

3. How long must a physician retain copies of medical records, including minors?

1. Adults: Ten years from rendering of service;
2. Minors: Ten years past age of twenty-one;
3. Deceased patients: Ten years from rendering of service.

Physicians do not need to keep copies of records and x-rays being properly retained by hospitals.

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"Ask a Lawyer' is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen of the Cline Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

ALLIANCE

Annual State Meeting
April 29 and 30, 1994

MONA DAMICO
Chairman, Resolutions

WHEREAS, we consider it fitting and proper to express our thanks to all who have contributed to the success of the convention and the accomplishments of the past year, THEREFORE BE IT

RESOLVED, that the members of the Nebraska Medical Association Alliance extend our sincere thanks and appreciation to the officers and other members of the Nebraska Medical Association Alliance Board of Directors who have so ably carried on the business necessary for the proper function of our organization and be it further

RESOLVED, that our thanks and appreciation be directed to the members of the Metropolitan Omaha Medical Society Alliance, host to this, the 69th Annual Meeting, for the gracious hospitality extended to us all; and be it further

RESOLVED, that we extend our welcome and thanks to Mary Hansen, President of the American Medical Association Alliance for her attendance at our convention; and be it further

RESOLVED, that we declare particular gratitude to the President of the Metropolitan Omaha Medical Society Alliance, Lenore Deeths, to our Convention Chairman Maria O'Donohue, their gracious committee and to all who have assisted so capably in planning for our comfort and pleasure; and be it further

RESOLVED, that the Nebraska Medical Association be advised of our appreciation of their assistance and leadership, in particular that of Robert F. Shapiro M.D. Also that the Commission on Association Affairs be informed of our gratefulness for their help and advice throughout the year and thank the Scientific Sessions Committee for generously sharing with us those portions of their program we are privileged to attend, and be it further

RESOLVED, that we make known to Mr. William Schellpeper, Executive Director of the Nebraska Medical Association, Mr. James Ruigh, Assistant Executive Director, and to their office staff, our deep appreciation of their support and assistance in all matters pertaining to the Nebraska Medical Association Alliance, and be it further

RESOLVED, that our thanks be extended to Dr. Benjamin Gelber, Editor of the NEBRASKA MEDICAL JOURNAL for the inclusion of the ALLIANCE NEWS page; to Elba Lau, Editor of the NEWSLETTER of the NEBRASKA MEDICAL ASSOCIATION ALLIANCE; to Medical Liability Mutual and Methodist Hospital for their interest and monetary support of our NEWSLETTER; and the state medical office personnel for their help in preparing material and mailing same, and be it further

RESOLVED, that we pledge our loyalty and devotion to the Nebraska Medical Association Alliance, that we continue to be faithful in supporting its activities, promoting its projects and protecting its reputation and high ideals and be it finally

RESOLVED, that these resolutions be published in the NEBRASKA MEDICAL JOURNAL.

WELCOME NEW MEMBERS

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COMING MEETINGS

CREIGHTON UNIVERSITY

MAY 19-22, 1994 — A Review of Orthopaedics and Orthopaedic Pathology - Criss II Building, Creighton University, Omaha, NE.

MAY 27-29, 1994 — Family Medicine Update, Okoboji, IA.

JUNE 6, 1994 — Medical Therapy of the Fetus - OB Outreach Program at Offutt Air Base, Omaha, NE.

JUNE 29, 1994 — Couple to Couple League - "Natural Family Planning: The Time Has Come" - St. Joseph Hospital, Omaha, NE.

JULY 27, 28, 1994 — Current Concepts in Subacute Care - Marriott Hotel, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

SEPTEMBER 29, 1994 — Ultrasonography - Marriott Hotel - Omaha, NE.

SEPTEMBER 30 - OCTOBER 1, 1994 — Day With the Perinatologists - Marriott Hotel, Omaha, NE.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 2500 California Street, Omaha, NE 68178.

MAYO FOUNDATION

SEPTEMBER 12-14, 1994 — The Norwegian-American Orthopaedic Society, Program site: Rochester, MN.

SEPTEMBER 23-24, 1994 — The Lower Extremity Amputee: A Multidisciplinary Approach, Mayo Foundation, Rochester, Minnesota, Registration fee: $300, 15 credit hours in Category I AMA.

OCTOBER 15-16, 1994 — International Symposium on Myeloproliferative Disorders, Program Site: Rochester, MN.

OCTOBER 23-27, 1994 — Advances in Diagnostic Radiology, The Cloister, Sea Island, Georgia. Registration fee: $595, 22.5 credit hours in Category 1 AMA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

METRO OMAHA MEDICAL SOCIETY/ OMAHA MIDWEST CLINCAL SOCIETY

SATURDAY, JUNE 18, 1994 — "Family Health Day at Henry Doorly Zoo", Omaha, NE. CME for physicans with added events for families. $120 for CME and family activities. Topics: Asthma, Diabetes, Cholesterol and Hypertension. 7 credit hours in Category 1 AMA and 6.5 credit hours AAFP.

TUESDAY, JUNE 7, & WEDNESDAY, JUNE 8, 1994 — Half day seminars on "The Art of Good Patient Relations" (training for physician's office staffs). Instructor: Janice K. Woerth, Ph.D. Washington D.C.

WEDNESDAY, JUNE 8, 1994 — "Reduced or Denied Claims: How To Prevent Them". Insructor: Janice K. Woerth, Ph.D., Washington D.C.

For further information on any of the above seminars contact the MOMS/OMCS, 7906 Davenport, Omaha, NE 68114, (402) 393-1415.

NEBRASKA MEDICAL ASSOCIATION

SEPTEMBER 15-17, 1994 — Fall Session, Cornhusker Hotel, Lincoln.

APRIL 27-30, 1995 — Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

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UNIVERSITY OF NEBRASKA MEDICAL CENTER

FRIDAY, MAY 20, 1994 — Symposium on Head and Neck Pain: Differential Diagnosis. Nebraska Center for Continuing Education, Lincoln, Nebraska. Target Audience: Physicians, Otolaryngologists, Dentists. Fee, $150.

FRIDAY - SUNDAY, JUNE 3-5, 1994 —Treatment for the Young Adult with Hip Disease, Red Lion Hotel, Omaha, Nebraska. Target Audience: Orthopaedic Surgeons, Fee: $500

THURSDAY - SATURDAY, JUNE 16 - 18, 1994 — 2nd Annual Diagnostic Dilemmas in Women's Health Care, Marriott Hotel, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Fee: $200.

MONDAY - TUESDAY, SEPTEMBER 12-13, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

SATURDAY, SEPTEMBER 17, 1994— 7th Annual Internal Medicine Update, University of Nebraska Student Union, Lincoln, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER, Fee: $45.

MONDAY, SEPTEMBER 26 — SATURDAY, OCTOBER 1, 1994 — Emergency Medicine, 1994, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

FRIDAY AFTERNOON, OCTOBER 7, 1994 — University of Nebraska College of Medicine Alumni Day (in conjunction with the Omaha Midwest Clinical Society Meeting), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: College of Medicine Alumni.

FRIDAY EVENING - MONDAY, OCTOBER 14-17, 1994 — Advanced Curriculum on Women's Health - Part II, Adam's Mark, Philadelphia, Pennsylvania, Target Audience: Primary Care Physicians.

SATURDAY, OCTOBER 22, 1994 — Evaluation and Management of the Swollen Extremity, Red Lion Hotel, Omaha, Nebraska, Target Audience: Primary Care Physicians.

For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuting Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

THURSDAY-FRIDAY, APRIL 21-22, 1994 — Symposium On Obstetrics & Gynecology, Location: St. Louis, Missouri.

FRIDAY-SUNDAY, JUNE 24-26, 1994— Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862.

The Hospital Medical Staff Section
23rd Assembly Meeting
June 9-13, 1994
Chicago Marriott Hotel
Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

Success will depend on unified physician support and action. Mark your calendar and plan to attend!

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2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

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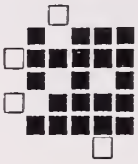

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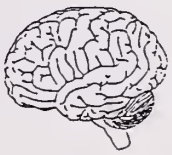

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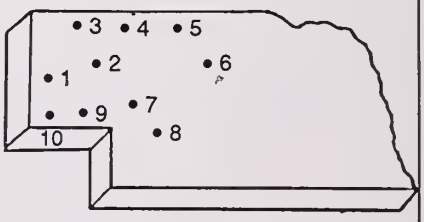

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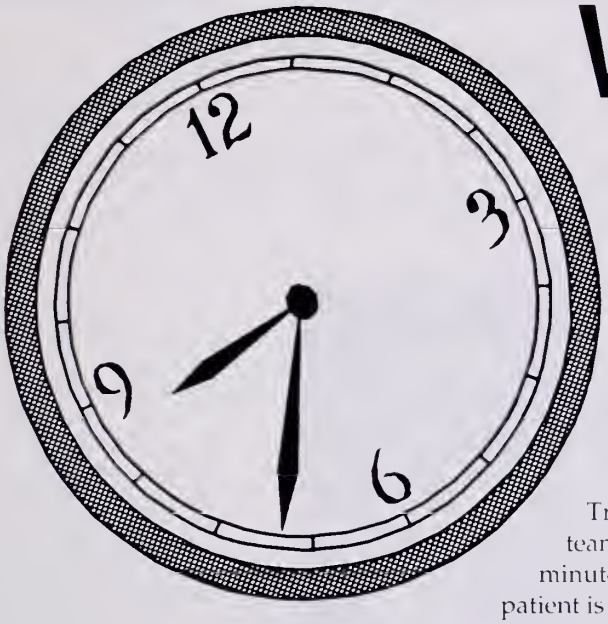

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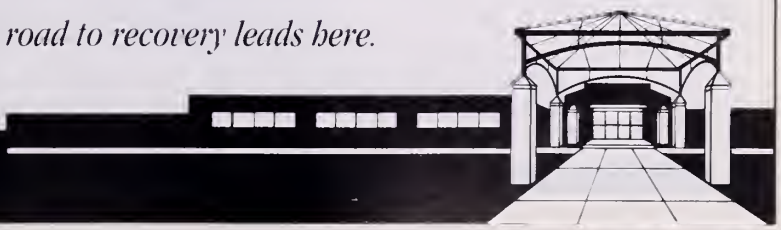

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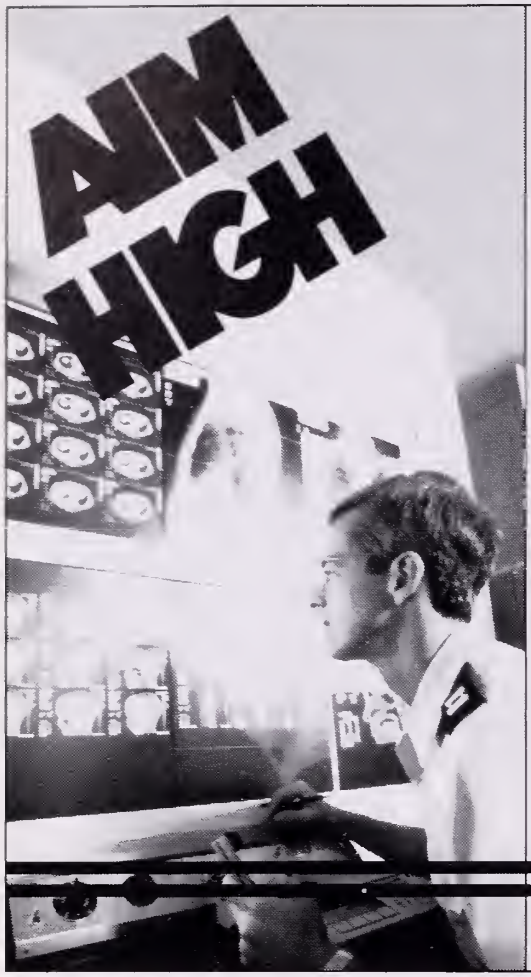

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2021 Spring Road, Suite 600, Oak Brook, IL 60521

AMA NEWS NOTES

AMA CHALLENGES INSURERS ON ANTITRUST

An AMA-sponsored ad in the May 12 *Washington Post* challenged the "Big 5" health insurance companies on the issue of antitrust reform.

The ad, headlined "What are they so afraid of?" read, in part: "For years, the insurance industry has been raising premiums, dropping people when they get sick, and denying coverage to patients who are already sick and desperately in need of care. So you can bet their opposition to the Health Care Antitrust Improvement Act isn't based on what's best for you. It's based on what's best for their bottom line."

The ad is part of the AMA's campaign for antitrust reform, as embodied in the Hatch-Archer legislation (S 1658 and HR3486). It also notes that insurance companies - which have mounted a vigorous campaign against physician-sponsored antitrust reform measurers - have themselves been exempt from antitrust laws for many years.

Copies of the ad suitable for publication are available by calling (312) 464-4400.

* * *

LETTER TO CONGRESS SUPPORTS ANTITRUST BILLS

The AMA and nearly 100 other medical groups sent a joint letter to every member of Congress, voicing support for the Hatch-Archer legislation and stressing the points made in the May 12 *Washington Post* ad.

Every state medical society and most major national specialty societies signed on to this strongly worded letter, stating, "The undersigned organizations want to clear away the insurance companies' smokescreen and refute scurrilous arguments" regarding the AMA's antitrust relief legislation.

The letter and the list of signers are available on the AMA Electronic Network; see LET 40512.TXT.

Also last week, AMA Vice Speaker Richard Corlin, MD, testified before the Senate Finance Committee on antitrust reform, supporting the Hatch-Archer legislation. His testimony may be downloaded from the AMA Electronic Network; see RFC40512.WP5 Word Perfect) or RFC40512.ASC (ASCII Text).

* * *

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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques. According to new 1991 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

Recommend

TODAY'S PORK

The Other White Meat

Nebraska Pork Producers Association
Attn: Jane Kreutz-Reeson
1222 L Street
Aurora, NE 68818

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PRESIDENT'S PAGE

Health Related Behavior Modification: The Role Of The Physician

FREDERICK F. PAUSTIAN, M.D.

As we are all aware, the major subject of discussion among physicians for the past 1-2 years has been health care system reform, not health care reform. The need for health care system reform is generally based on two factors: 1) lack of access to health care by approximately 15% of the United States population, and 2) the cost of medical services - a great concern of government, industry, the medical profession, and individuals. As stated in a previous editorial, the total cost of medical care equals volume of services times price. Much effort is currently being devoted to health care system design which will reduce overall costs of medical services mainly through the managed cared approach to delivery of medical services. The reduction of volume of medical care has received much less attention as it tends to be equated to rationing of the delivery of medical services. An area where health care reform is needed and about which relatively little has been written or done is the modification of unhealthy lifestyles of many of the citizens of this country. Through behavior modification of such lifestyles, a distinct reduction in health care volume and cost should be obtainable.

The Scientific Sessions Committee of the Nebraska Medical Association has recognized the need for behavior modification of our society as an important preventive measure to improve health. In its annual scientific programs for the past two years, the NMA has focused on societal problems in health care that have a serious impact on all of us. In 1993 attention was directed at the distribution of the health care dollar as to, "who gets what?", with the societal concern focused on, "how can we most effectively and efficiently expend the health care dollar?" At the 1994 Annual Session, the societal problem of domestic violence and abuse was the theme with major attention being given to recognition of behavior characteristics leading to violence so as to permit both preventive and rehabilitative therapy. Underlying this excellent program was the recognition that prevention of physical and mental injury through behavior modification would not only improve health but markedly reduce health care costs.

Frederick F. Paustian, M.D.

When reviewing age, sex and race related tables and graphs on the leading causes of morbidity and mortality, one becomes very disturbed that these high frequency diseases have a striking pathogenic correlation with unhealthy behavior.

Examples are as follows:

- Heart disease - smoking and obesity
- Cancer - smoking, alcohol, and in some instances sexual promiscuity
- Cerebral vascular disease or strokes - smoking and obesity
- Chronic lung disease - smoking
- Motor vehicle accidents - alcohol and drug abuse
- Suicides and homicides - disturbed emotional states, alcohol and drug abuse
- Cirrhosis of the liver - alcohol and drug abuse and sexual promiscuity
- AIDS - sexual promiscuity, drugs and alcohol abuse
- Alcoholism - alcohol
- Non-vehicular accidents - violence secondary to disturbed emotional states, alcohol and drug abuse.
- And the list goes on and on.

While all of us as physicians are very much aware of these pathogenic mechanisms underlying the listed diseases and we have great empathy for the consequences and the related pain and suffering of our patients and their families, what are we as physicians doing in a meaningful manner to alter the behavior leading to the problems? Reed Tuckson, M.D., President of the Charles R. Drew University of Medicine and Science, spoke at the AMA 1994 National Leadership Conference in San Francisco, and very cogently assessed the problem when he stated, "Pity and compassion in a world of pain means nothing without change." It, therefore, becomes extremely important for us, as physicians, to appreciate the pathogenesis of these diseases and, when related to unhealthy behavior, initiate the process of effecting change in our patients in order that we may avert the otherwise steady progression toward illness and death. We physicians, as the principle providers of health care, must educate our patients as to appropriate, healthy lifestyle habits. If we want our patients and society to have a happy, healthy life, they must be educated to accept responsibility for self conduct of a healthy lifestyle.

Physicians must be sensitive to those circumstances evident in the patients history which lead to impaired health both emotionally and physically. Unfortunately, when we recognize illness as a consequence of inappropriate behavior, such as domestic violence, we must become involved because we have the responsibility of being the caretakers of our patients health. Involvement in this type of health problem often means a major commitment of time and effort including interaction with our law enforcement officials and legal colleagues.

The accurate diagnosis and treatment of disturbed emotional states as depression is essential to the prevention of long-term morbidity as well as suicide. Unfortunately, recognition of such depression disorders in certain segments of our population, as the adolescent, is widely undiagnosed and accordingly not treated. Therefore, recognition of the problem is of paramount importance if we are to effectively intervene and bring about change or make the appropriate referral to skilled health providers who can effect change through behavior modification.

While there a numerous publications available within our medical periodicals and there are many continuing medical education courses which will prepare us for the recognition of behavior based disease, many physicians are not aware of the resources available for treatment. Within the State of Nebraska and in certain communities there are networks of agencies and personnel who are available to provide us help in the treatment of behavioral disorders. These include the Nebraska Domestic Violence and Sexual Assault Coalition, the Legal Assistance Foundation, and the Omaha Community Partnership as just a few entities which can facilitate or provide direction to the most appropriate personnel for the care of our patients. Physicians must prepare themselves to manage societal health problems through the utilization of these important agencies and their skilled personnel who are capable of intervening and reversing detrimental behaviors.

While of limited availability at the present time, a near future resource for effective management of behavioral problems are nurse practitioners. We should recognize, appreciate, and accept their skills as very interactive health care providers who can, in a collaborative relationship with physicians, be very effective investigators and bring about change though counseling and education of our patients. While embracing these mid-level practitioners, we must be of further assistance to them by promoting the recognition of the value of their services by health care insurers and other payers so as to permit adequate compensation for the skills they utilize to bring about the change of unhealthy behaviors. By so doing, it is very likely that we can bring about a reduction in the volume of health care and thereby significantly contain costs.

It is also important that we, as an association of physicians, influence in every way possible other methods of patient education than direct interaction. There are many behavioral problems among our society which have not reached the stage where the individual seeks medical care. These troubled persons also require education as to the detrimental potential of their behavior. It is important that our organization work together with representatives from all education systems to bring to the attention of the communication media the necessity for the promotion of healthy lifestyles through education. There are many mass media mechanisms which must be employed including newspapers, periodicals, radio, TV, movies and other audiovisual technologies, as TV tapes and compact discs. Innovative message delivering meth-

ods should also be tried as commercials and entertaining musical lyrics which promote healthy lifestyles. If these methods of communication and entertainment contributed to the establishment of unhealthy behavior as acceptable or the norm, why not use these same tools to establish healthy lifestyles? It is, therefore, intended to have our education committee become very involved in promoting healthy behaviors through mass media communication methods.

Among the many necessary objectives for the Nebraska Medical Association during the coming year, a major effort will be extended to plan, promote and present programs on societal health problems in close association with and the participation of the Nebraska Medical Association Alliance who are also challenged by this very difficult health issue. In this category of health care, there is a need for health care reform.

GUEST EDITORIAL

You're Late!

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Diseases and Surgery of the Skin
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It has been a morning from hell. The first three patients brought their "shopping list" of ailments varying in length from six to ten, mostly unrelated. Three of the next six brought a spouse along whom you could surely take a "quick" look at, as long as they were in the office, anyway. And the mildly-confused senior from northern Kansas had come on the wrong day; you just cannot send her back home untreated.

Your office staff is becoming mildly irritated about having another lunch hour cut short, and you're feeling a little weak yourself as you enter the last room. There you meet that stone-cold stare, that palpable hostility, of the patient you have kept waiting for over an hour, and who has no tolerance for being delayed. The ensuing exchange is certain to be most unpleasant. How do you handle it?

This situation happens to all of us, usually precipitated by factors out of our control, and contributed to, in part, by our compassion in dealing with other patients earlier in the schedule. As with most unpleasant situations in practice and in life, it is best dealt with by thoughtful preparation. In this case, a few rehearsed responses can be extremely helpful.

Before discussing specific responses, the most important factor in approaching these situations is, simply: "Chill out!" Most people drop their hostility if not challenged. It is your fault that you are so far behind, but it only happens because you are so compassionate and so popular! These are positive attributes and give you the confidence to ward off the hostility. I find, in most cases, a simple reply, prefaced with an apology is sufficient to defuse the anger. "I'm really sorry, no one hates falling behind more than I do," almost always works.

But what about those special situations? It can't hurt to have some quick retorts handy when the situation calls for one to lighten up the moment. If your patient is good-natured and not terribly perturbed, I like to point out that "nobody likes to go to the empty restaurant." Or alternatively, also pointing to one positive aspect of the problem — your popularity, invoke Yogi Berra, "The place is so busy nobody comes here anymore."

If the pressure to defend your office is somewhat more intense, other comments may help explain the difficulties you had staying on schedule. These remarks should all be prefaced by "I really apologize to you, but . . ." Again focussing on your popularity and your humanity, "The only way I can possibly keep up with the demand for my service is to fill every available appointment slot, my wife won't let me take more time from the family by expanding the schedule." Or alternatively, "I'm already working 60 hours per week, and I seem to be getting slower as I get older." or, "I could keep on schedule if I didn't visit with my patients so much."

Rarely, the complainer is a patient that rubs you the wrong way, and has done so on other occasions. This individual can be handled with considerably more flexibility. To the irritating pronouncement of, "You make me so mad, I'm never coming back!", you can blithely point out the logical inconsistency of the statement. You might reply, "You've been in my waiting room, you can't possibly perceive I would consider that threat!" On rare occasion you may feel a little irritated yourself, and remark, "I would appreciate if you didn't, but you will only help the situation a little." Or perhaps, "If half of my practice felt that way, it would only improve the quality of my life!" I have, personally, never tried any of these, but I am keeping them in abeyance should the appropriate circumstance present itself.

Finally, I would like to share my best-ever, never-fail response to be used when confronted by the initially-hostile woman patient who has unfortunately been detained much longer than is ever your intention. After giving her ample opportunity to verbally vent her anger on me, I put on my finest "hurt dog" countenance and woefully intone, "After the morning I've had, if you are going to be mean to me, too, I'm just going to cry!" More often than not, the return comment goes something like, "Oh Doctor, I'm so sorry!"

ORIGINAL ARTICLE

Cholesterol Lowering With Drugs: A Review Of The Primary Prevention Trials

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220 South 17th Street
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ABSTRACT

This paper reviews the studies of drug treatment of hypercholesterolemia in the primary prevention of coronary disease and concludes that the data do not justify the current recommendations for cholesterol lowering.

INTRODUCTION

REDUCING blood cholesterol has, in some studies, been shown to have a slight but probably clinically important effect on reducing cardiovascular morbidity and mortality in asymptomatic men. Unfortunately, reducing blood cholesterol also increases overall mortality making treatment difficult to justify in most circumstances. Given these facts it is difficult to understand the rational behind the 'consensus' recommendations of the National Institutes of Health.[1,2] Oliver[3] has pointed out that the recommendations did not truly represent a consensus. Ahrens[4] reviewed the data on which the recommendations were made and concluded that they had little scientific justification. Muldoon and others[5] suggested in 1990 that cholesterol lowering with drugs seems to increase overall mortality, and Smith and others[6] in a large meta-analysis have shown that most patients with hypercholesterolemia will be harmed by drug treatment.

Because of the continuing controversy, I have reviewed the primary prevention trials which investigated the use of drugs to lower cholesterol. Secondary prevention trials have been reviewed by Rossouw and others.[7] This review has been further limited to pure cholesterol lowering trials -- eliminating from consideration all the multiple risk factor intervention trials.

While the general statistical relationship between elevated cholesterol and vascular disease is well established for the population as a whole,[8 (p1036), 9,10,11] the variability of this relationship in various sub-populations is not so clear. Further, the relationship betweeen cholesterol and overall mortality is even less certain.

Having low cholesterol may be a predictor of increased mortality[12] and, in particular, may be asociated with an increased risk of cancer[13] (although this asssociation was not seen in all studies[14]), and in men (but not women), death from injuries (including suicide).[15] An analysis of MRFIT data suggested that the lowest mortality is obtained in persons with cholesterol between 160 mg/dl and 240 mg/dl with rising mortality rates on either side.[16]

The importance of cholesterol as a risk factor in older persons is uncertain. A thirty-year follow-up[17] of Framingham data showed no increase in mortality in persons with high cholesterol over the age of about fifty-five, although reanalysis of the same data[18]suggested a trend towards increasing mortality with increasing cholesterol which only reached statistical significance for women with cholesterol >305mg/dl. A study from Hawaii,[19] however, showed an increased coronary morbidity and morality in men over sixty-five with elevated cholesterol, although the study did not report on all-cause mortality. A long term follow-up of English data[20] suggested that cholesterol remained predictive of both cardiac and total mortality at least to age 69 but that after 70 the increased death rates from heart disease in people with high cholesterol were offset by increased death rates from cancer in those with low.

Much of the work on the relationship between cholesterol and vascular morbidity has been done in men and both Crouse,[21] in a review, and Isles and others[22]using prospective data concluded that the association is quite weak for women except at very high cholesterol levels. Pocock and Seed[23] analyzing British data on men and women aged 65-74, noted that the association between elevated cholesterol and heart disease was very weak in the women, but strong in the men even though the women tended toward much higher cholesterol than men. They were not able to see any

association between cholesterol and over all mortality in either sex.

All of the above is interesting but the question we really want answered is whether lowering cholesterol lowers the risk of death or complications from vascular disease (and with what side effects) and, if it does, who will benefit and at what cost. This requires a review of the clinical trials.

THE TRIALS

Trials of dietary modification are beyond the scope of this paper — Oliver[24] has provided an excellent summary of them concluding that:

> There is no consistently significant relation between the constituents of the average daily diet and serum lipoprotein concentrations within populations or in individuals . . . No major prospective controlled trial of a low-fat diet has been conducted, mostly for logistic and economic reasons . . . I am unconvinced that reduction in the dietary fat of the whole nation has made or will likely make a major contribution to the national incidence of (coronary heart disease) . . .

although he goes on to suggest that there may be some suggestive evidence that dietary modification may be useful for those in the upper quintile of LDL cholesterol. Dayton, and others[25] have summarized the uncontrolled dietary trials up to 1969 and provide an excellent analysis of the larger problem of dietary change in large open populations.

THE WHO TRIAL

In 1978[26] a large three center European study of clofibrate was reported — the World Health Organization Trial. This primary prevention trial recruited about 15,000 men age 30-59 without any evidence of cardiac or other serious disease. Ten thousand of the men were in the upper one-third of the cholesterol range (about 250mg/dl); these were divided into two equal groups, one given clofibrate and the other placebo. The third group of 5,000 men had low cholesterol (about 180mg/dl) and served as a second control group. Clofibrate lowered cholesterol by about 9%. The initial report of the study showed a 20% decrease in ischemic heart disease (confined to non-fatal myocardial infarction) in the clofibrate group but with a slight increase in the all-cause mortality (due to an increase in the non-cardiac, particularly gastrointestinal mortality in the treatment group). The greatest benefit for ischemic heart disease was seen in men who had the greatest reduction in cholesterol. In 1980, a follow-up study[27] was reported and this showed an increase of 25% in the all-cause mortality in the clofibrate treated group compared to the high cholesterol control group and this increase was seen in ischemic heart disease, stroke, and cancer. There was also an excess death rate in the clofibrate treated group compared to the low cholesterol control group. This was a post hoc analysis and not part of the original study design.

LIPID RESEARCH CLINICS TRIAL

In 1973 the National Heart, Lung, and Blood Institute organized the Lipid Research Clinics — Coronary Primary Prevention Trial. The primary results were published in 1984.[28] The trial lasted 7.4 years and consisted of 3,810 middle-aged men without evidence of prior ischemic heart disease and with cholesterol levels of about 290mg/dl and triglyceride levels of about 160mg/dl and with no other serious medical or psychological problems. The men were not randomly selected from the population, but rather were recruited by advertisement or were referred from specialized lipid clinics. (This method of selection introduces a sort of 'volunteer bias' into the study — not the sort of bias seen in studies that compare volunteers to non-volunteers — but rather the bias that makes it difficult to generalize the study results to the population as a whole.) The medication used was cholestyramine in a dose of 24 grams/day (that is 6 scoops or packets of Questran®/day). Both groups were put on a cholesterol lowering diet. The treatment group had a substantially lower cholesterol at the end of the trial compared to the control group. There were 256 definite or suspected coronary heart disease deaths or non-fatal myocardial infarctions out of 1,900 persons in the control group (13.5%) and 222 out of 1,906 in the cholestyramine group (11.6%). The all-cause mortality was not changed (about 70 in each group). The difference was accounted for by a greater number of accidental and violent deaths in the cholestyramine group. An accompanying report[29] showed that the level of decrease in coronary heart disease events was directly and clearly related to the reduction in cholesterol (particularly to reduction in LDL cholesterol and slightly to increase in HDL cholesterol). This secondary, post hoc analysis has been widely quoted but the results may not be true. In particular, there was no matched comparison

of men who took their cholestyramine regularly with men who took their placebo regularly.

The trial had numerous limitations. It looked only at men and its results are not generalizable to women. It looked only at persons with quite high cholesterol (291.5mg/dl +/- 33.6) and the results are not necessarily generalizable to patients with moderate elevation in cholesterol or with normal cholesterol. To quote, on this topic, an editorial[30] from the British Medical Journal:

> There are those who will be quick to extrapolate the positive findings of the Lipid Research Clinics Trial to people with lower concentrations of serum cholesterol and LDL cholesterol, and many others who will wish to infer that cholesterol lowering diets will have a similar effect. But we should be wary of overinterpretation in either of these directions. The results of the trial apply only to the top 5% at risk and, as the authors state, the trial was not designed to test the dietary hypothesis.

The authors make the claim that for each 1% decrease in cholesterol, there is a 2% decrease in coronary artery disease morbidity and mortality. This claim is true as far as the study population goes (that is, middle-aged males with cholesterol of about 290mg/dl) but it cannot be assumed that the result can be linearly extrapolated to lower cholesterol levels, or that it can be applied at all to women or to older or younger men.

The trial claims to be a trial of lowering coronary heart disease morbidity and mortality by lowering cholesterol while in fact it is a trial of lowering coronary heart disease morbidity and mortality by giving cholestyramine. The authors claim that because cholestyramine is neither absorbed nor metabolized and its only known effect is to lower cholesterol the claims are the same. This is probably true, but not necessarily true for two reasons: First, the 'unknown unknown' problem. That is, that while cholestyramine has no other known effects, it might have unknown effects that influenced the outcome of the trial. Second, cholestyramine does have one other known effect, it interferes with the absorption of many drugs. Whether this influenced the results of the trial is unknown.

The mortality and morbidity rates seen in the LRC Study are about two and a half times greater than those seen in the WHO Study and the Helsinki study (see below) implying that the men in the LRC Study were, a priori, at increased risk for vascular events. This in turn reminds us that the participants were not randomly selected from the population but were volunteers in two senses: they were self-selected to be at the Clinics in the first place and then they were self-selected to be in the trial. This does not in any way take away from the conclusions reached in the trial except to say that the conclusions may be applicable only to highly motivated men at high risk and not necessarily to normally motivated men at average risk.

A major criticism of the trial is that it looked only at cardiac morbidity and mortality and not at overall morbidity and mortality. This was done for the simple reason that a trial powerful enough to find a statistically significant difference in overall mortality would be prohibitively expensive. When overall mortality was considered as a secondary end point, there was no reduction. It has been argued that accidental and violent deaths (the major cause of the lack of difference in mortality) have no importance to coronary artery disease mortality. The reply of course is that:

- the two groups were comparable in which case the (secondary end-point) finding stands that cholestyramine gives no overall benefit (although some cardiac benefit) or,
- the two groups are not comparable in which case none of the results of the trial stand including its claim to reduce morbidity or mortality from coronary heart disease or,
- the trial was not powerful enough to detect a difference in overall mortality, and therefore no recommendation can be made as to whether lowering cholesterol by giving cholestyramine has any overall benefit.

HELSINKI HEART STUDY

In 1987, Frick and others[31] presented the results of a five year placebo controlled, double blind, randomized trial of gemfibrozil (Lopid®) 600 mg. given twice a day. The study group consisted of about 4100 middle-aged men without any evidence of coronary heart disease or other serious illnesses (except for mild or moderate hypertension, "mild" type II diabetes, and smoking), and with a non-HDL cholesterol greater than or equal to 200 mg/dl. There were no women in the trial. Gemfibrozil was used as the study drug because it is known to not only

lower LDL cholesterol but also to raise HDL cholesterol. At entry, the men had total cholesterol of about 290mg/dl, HDL cholesterol of about 47mg/dl, and triglycerides of about 175mg/dl. The study group lowered their total cholesterol by about 8%, their LDL cholesterol by 8%, their triglycerides by 35%, and raised their HDL cholesterol by 10%. The drug was well tolerated.

The primary end-point of the study was cardiac events, both possible and definite (fatal and non-fatal myocardial infarction, sudden cardiac death, unwitnessed cardiac death). Death was not a study end-point, this again because of considerations of sample size and cost. There was a 34% reduction in the rate of cardiac events (from 41.4/1000 in the control group to 27.3/1000 in the active treatment group). Essentially all of the benefit was seen in the category of non-fatal myocardial infarction (35.0/1000 vs. 21.9/1000). There was, yet again, an increase in the death rates from accidents and violence in the active treatment group (4.9/1000 vs. 2.0/1000) although this difference did not reach statistical significance. There was no change in the overall death rate (active 21.9/1000 control 20.7/1000).

All of the criticisms of the cholestyramine study (except those relating to the randomness of the participants) can also be made of this study. In particular it should be noted that there are now two well organized and well run studies which suggest but do not prove that lowering cholesterol (or at least taking drugs which lower cholesterol) makes one more likely to die of an accident or violence, and three studies which suggest but do not prove that lowering cholesterol has no positive effect on mortality.

The authors of the gemfibrozil study attempt to draw the conclusion that raising HDL cholesterol lowers the risk of heart disease because their study drug has this effect (as well as its lowering effect on LDL cholesterol). This conclusion is not supported by their study design. In particular, the initial selection was based on the level of non-HDL cholesterol (>200mg/dl) and not on the level of HDL cholesterol. If instead they had chosen 4000 men with HDL cholesterol of say 20mg/dl and with random total and LDL cholesterol levels and then shown that raising the HDL cholesterol levels with gemfibrozil was associated with a reduction in cardiac mortality, their claim would have merit.

About a year after the publication of their original paper, the authors of the Helsinki study undertook an extensive post hoc re-analysis of their data[32] in which they further investigated the question of the relationship between the rise in HDL levels and the decline in the incidence of coronary artery disease. This analysis, while very complex and detailed, suffers from the same faults of all such analyses — although interesting hypotheses can be developed from them, no firm conclusions can be drawn. It is certainly an interesting hypothesis that raising HDL levels is a 'good thing' but the published analysis above does not prove the point.

OTHER CHOLESTEROL PROBLEMS

There have been no studies done examining modification by drugs of the various cholesterol sub-fractions and, in particular, there have been no studies specifically directed at modification of HDL cholesterol.[33] There have also been no studies showing that routine treatment of hypercholesterolemia is beneficial in children. There are significant problems in measuring cholesterol, both technical[34,35,36,37] and biological.[38,39,40]

META-ANALYSIS

None of the three major cholesterol trials have had the statistical power to detect a significant difference in overall mortality and therefore no statement can be made with certainty about the overall benefit or harm from cholesterol lowering. The best available answer to this problem, however, can be obtained by combining the results of the individual trials — giving us about 9,000 men in each of the treatment and control groups. The results of such an analysis can be seen in the Table.

This not very sophisticated analysis is acceptable here as all the trials were organized in basically the same manner. Better methods of analysis are available but are quite complex. No attempt is being made to calculate significance values. This sort of analysis is designed only to show trends not to supply proof. The trends that are seen, however, are quite clear and are consistent from trial to trial — lowering cholesterol by any of the drugs used seems to cause a small but clinically significant reduction in the incidence of both coronary 'events' and coronary deaths, but that this beneficial effect is more than offset by an overall increase in death rates in the treatment groups with the final outcome being that you are more likely to die if you get your cholesterol lowered.

Trial	Drug:	Number of Patients	Definite CAD death or non-fatal MI	Total CAD mortality	All-cause mortality
WHO	Clofibrate:	5331	167(3.1%)	36(0.7%)	162(3.0%)
	Placebo:	5296	208(3.9%)	34(0.6%)	127(2.4%)
LRC	Cholestyramine:	1906	155(8.1%)	30(1.6%)	68(3.6%)
	Placebo:	1900	187(9.8%)	38(2.0%)	71(3.7%)
Helsinki	Gemfibrozil:	2051	56(2.7%)	14(0.7%)	45(2.2%)
	Placebo:	2030	84(4.1%)	19(0.9%)	42(2.1%)
Total	Treatment:	9288	378(4.1%)	80(0.9%)	275(3.0%)
	Placebo:	9226	479(5.2%)	91(1.0%)	240(2.6%)
Rate/1000	Treatment:		40.7	8.61	29.6
	Placebo:		51.9	9.86	26.0
Absolute change /1000 Rx. vs Placebo			-11.2	-1.25	+3.6
Percent change, Rx vs Placebo			-21.6	-12.7	+13.8

TABLE - META-ANALYSIS

CONCLUSIONS

There is good scientific evidence that if your patient is a healthy, middle-aged man with a total cholesterol of about 290mg/dl, giving him 24gm/day of cholestyramine or 1200mg/day of gemfibrozil will slightly reduce his likelihood of having a heart attack or of dying of coronary heart disease but there is no evidence that either drug will reduce his risk of dying. Specifically, you'll reduce his chances of a coronary event by about 20% over five to seven years or, to put the same numbers into a more clinical perspective, you'll increase the chances of his not having a coronary event from about 95% to about 96% — numbers depend on which trial you look at. There is no evidence that any other drug (including lovastatin and its cousins) is helpful — and there is evidence, not discussed here, that some (d-thyroxin, and estrogens) are harmful — or that any dietary treatment (including fish) is of any use. There is some evidence that having a naturally low cholesterol is beneficial but there is no evidence that lowering cholesterol is useful (only that giving cholestyramine or gemfibrozil may be). There is no evidence that 'treating' HDL cholesterol or HDL/total cholesterol ratio is useful. There is no evidence that any sort of treatment of any sort of cholesterol in women or children is useful.

The data presently available do not support the current recommendations for aggressive cholesterol lowering.

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ORIGINAL ARTICLE

Nonthoracotomy Implantable Defibrillator: The Initial Nebraska Heart Institute Experience

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INTRODUCTION

SUDDEN unexpected death secondary to ventricular fibrillation remains a major health problem in the United States. The poor performance of antiarrhythmic drugs prompted the development and the continued use of the implantable cardioverter defibrillator (ICD). The use of the ICD has improved arrhythmic mortality rates.[1-3] Unfortunately ICD patients have required major operations (usually thoracotomy, median sternotomy, or subxiphoid incision) which has significant morbidity and mortality. We have utilized a new nonthoractomy lead system for ten consecutive ICD implants. Those ten patients are now reported.

METHODS AND MATERIALS

Ten consecutive patients undergoing AICD implant who did not require other cardiac surgery are reported. Five males and five females ages 48 to 74 underwent ICD implant utilizing the nonthoractomy lead system. (Figure 1) Seven patients survived out of hospital cardiac arrest and five had sustained ventricular tachycardia that was hemodynamially compromising. Five patients had coronary artery disease and five had cardiomyopathy. The ejection fraction was 10 to 55 percent with a mean of 32 percent. Cardiac Pacemaker Inc. of Minneapolis, Minnesota (CPI) Endotak system was utilized as part of a Phase III multi-center research project sponsored by CPI and approved by the Bryan Hospital Institutional Review Board. CPI defibrillator generators were used, nine patients had Model 1600 and one patient had Model 1555. The lead utilized the distal electrodes for sensing and two large electrodes; one in the right ventricular apex and the other in the superior vena cava or right atrium are used for delivery of the shock.

All implants were performed in the operating room under general anesthesia by one cardiovascular surgeon and one cardiac electrophysiologist. The lead was positioned under fluroscopy and defibrillation thresholds were performed. In one patient defibrillation threshold was greater than 20 joules so a subcutaneous patch was utilized. In one patient with severe left ventricular dysfunction (ejection fraction was less than 10 percent) the lead alone was not tested. Defibrillation thresholds were less than 20 joules and ventricular tachycardia was tested and successfully terminated when clinically indicated. All patients received pre and post-operative antibiotics and digoxin. Patients remained hospitalized for two to five days following surgery.

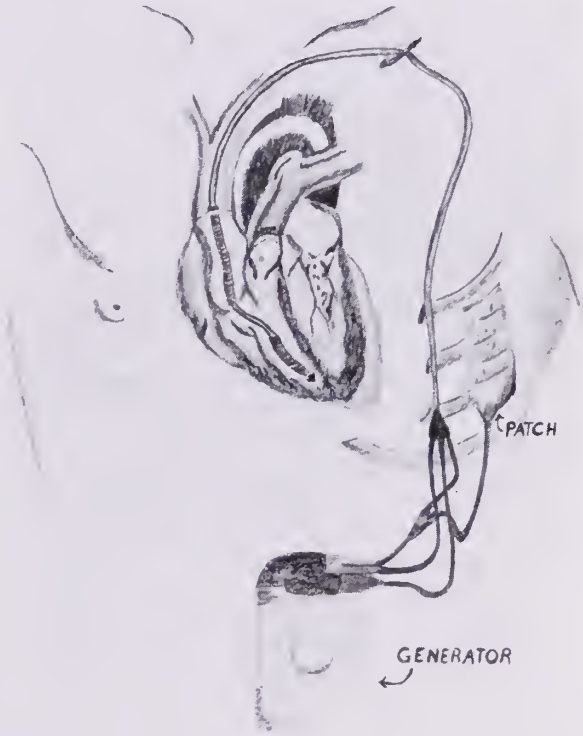

FIGURE I
Illustration of the Endotak AICD system utilized in this study. The endocardial lead (Endotak) is positioned in the right ventricle (similar to a standard pacemaker lead). The subcutaneous patch is utilized when necessary.

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RESULTS

All patients survived and remain alive at a mean of 6 months after surgery. The lead alone was used in eight patients and the lead and subcutaneous patch was utilized in two patients. The initial lead position was used in nine patients. One required repositioning and eventually a subcutaneous patch. No patients required thoracotomy or median sternotomy. One patient required lead repositioning. One patient had a wound hematoma that was drained uneventfully. There were no other complications. Post-op hospital stay was 2-5 days mean = 3.7. There were no rehospitalizations for complications. All patients were ambulatory within 12 hours following surgery. Predischarge electrophysiology study under local anesthesia showed successful conversion of ventricular fibrillation with one ICD discharge in all patients.

DISCUSSION

Implantable cardioverter defibrillator has become the mainstay in the treatment of malignant ventricular arrhythmias. These devices prevent sudden death from ventricular tachycardia and ventricular fibrillation in most patients.[1-3] Operative mortality and morbidty have slowed even more widespread use of these devices. The Endotak system we utilized in this report may have a significant impact on this morbidity and mortality and may increase utilization of this device.

Implantation of ICD has involved direct attachment of the shocking and sensing leads to the pericardium or myocardium, usually through thoracotomy or median sternotomy. Significant and obvious morbidity is associated with these procedures. Implantation of the lead system described here involves only minor surgery on the chest wall.[4-5] No significant morbidity and only two minor complications occurred in the patients reported here.

Long-term results with this system appears comparable to standard epicardial systems.[7] There is a trend toward improved mortality.[8]

CPI reports 86 percent of patients can be successfully implanted with this system,[7] but we have been successful in all patients. They also report 57 percent of patients have utilized the lead only (no subcutaneous patch).[7] We were successful with the lead only in 80 percent of our patients.

The average post-op hospital stay, 3.7, days was substantially shorter than for epicardial lead systems (6 days). This shortened stay should result in significant decrease in patient charges and a 33 percent decrease in convalescent charges has been reported.[9]

In summary, we present 10 patients who received an experimental endocardial ICD lead system (this system is now FDA released). None of these patients required thoracotomy. Shortened convalescence both in and out of hospital decreased cost, decreased morbidity and probably decreased operative mortality are possible with this system. Based on our initial experience as well as the experience of others, we feel this system is the method of choice for ICD implantation and in most patients will quickly supplant the epicardial system previously used.

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PERINATAL PAGE

Fetal Echocardiography: An Overview

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THE fetal heart is the most susceptible organ to congenital malformations. Congenital cardiac anomalies occur approximately six times more frequently than neural tube defects and ten times more frequently than anomalies of any other organ system. Congenital heart disease (CHD) accounts for approximately 25% of all fetal anomalies. Six to 10 neonates per 1,000 live borns are diagnosed with CHD.[1,2]

With advances in ultrasound imaging techniques, abnormalities of fetal cardiac anatomy, function, and rhythm can now be detected as early as 16 weeks gestation. Recognition of complex CHD in utero can expedite perinatal and neonatal management, resulting in more favorable clinical outcome.[3] Effective treatment of life-threatening arrhythmias is now possible before birth because of accurate fetal echocardiographic diagnosis.

INDICATIONS:

Although most cardiac anomalies occur in pregnancies without identifiable risk factors, there are recognizable clinical situations in which risks of fetal CHD are high and fetal echocardiography might be helpful. Indications for a fetal echocardiogram can be subdivided into three major risk groups: familial, maternal, or fetal.

(1) ***Familial:*** The average recurrence rate for congenital heart disease varies from 3-5% with one previous affected child, 10% with 2 previous affected children and 10-15% with a parent with CHD. Lesion-specific rates may vary. Higher recurrence rates have been a parent with CHD. Lesion-specific rates may vary. Higher recurrence rates have been reported with left-sided lesions such as hypoplastic left heart syndrome and coarctation of the aorta.[4,5]

(2) ***Maternal:*** Maternal exposure to drugs, teratogens, infectious agents, or altered metabolic states (such as diabetes mellitus) increase the likelihood of cardiac malformations. The overall risk from maternal causes is estimated to be approximately 2%.

(3) ***Fetal:*** Fetal structural abnormalities, chromosomal abnormalities and fetal arrhythmias are the most common fetal indications for a detailed cardiac evaluation. These indications generally have very high yield for cardiac anomalies. Copel estimates that 5-45% of fetuses with extracardiac defects will have cardiac anomalies.[6] Amount this high risk group, renal, mediastinal, and ventral wall defects have a higher frequency of fetal CHD compared with CHD rates accompanying isolated central nervous system or gastrointestinal defects. Cardiac anomalies are seen in 50-90% of fetuses with chromosomal abnormalities diagnosed in utero. Mechanisms for important fetal arrhythmias (supraventricular tachycardia, atrial flutter, atrioventricular block, ventricular tachycardia) are often diagnosed by fetal echocardiography.

FETAL ANATOMY AND PHYSIOLOGY:

There are many unique features of the fetal heart and circulation relevant for the sonographer. The heart of the fetus lies horizontally in the thoracic cavity and occupies approximately one-third of the thoracic volume. The apex points to the left and the ventricles are rounded in appearance and are approximately equal in size.[7] In the fetus, blood flow is altered by the presence of one intracardiac (foramen ovale) and two extracardiac shunts (ductus venosus and ductus arteriosus). Oxygen-rich blood from the umbilical vein is directed across the foramen ovale to the left atrium preferentially to the head vessels. Blood from the right ventricle is diverted from the lungs through the ductus arteriosus to the descending aorta.

Certain cardiac lesions seen post-natally are secondary to defects in cardiac morphogenesis, rather than cardiac embryogenesis. Since the heart is completely formed by 8 weeks gestation, human cardiac embryogenesis is

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FIGURE 1
This shows a typrical 4-chamber view of the heart. The left atrium is closest to the spine and descending aorta. LA=left atrium, RA=right atrium, LV=left ventricle, RV=right ventricle, Desc=descending.

FIGURE 2
This is a long axis view of the heart showing the aorta coming off the left ventricle.

never seen echocardiographically. However, cardiac morphogenesis, i.e. growth of the cardiac chambers is ongoing throughout pregnancy and is a function of cardiac work and distribution of blood flow. Some lesions, such as hypoplastic left heart syndrome and coarctation of the aorta, are known to "evolve" through pregnancy with decreasing left ventricular or transverse aortic size associated with decreased flow across the mitral valve or transverse aorta.[8]

EXAM TECHNIQUE

The fetal echocardiogram consists of three basic components - 2-dimensional, Doppler ultrasound, and M-mode (or motion-mode) echocardiography.

(1) ***2-dimensional:*** The 4-chamber view (Figure 1) can be obtained in 90-95% of infants older than 18 weeks gestation.[9] From this view, the size of the heart, position of the heart, atria, ventricles, ventricular and atrial septa, atrioventricular valves and the crux of the heart can be inspected. The ventricles should be of equal size, appropriate thickness and have good contractility. Approximately 80-90% of fetuses with congenital heart defects have an abnormal 4-chamber view.[10] Therefore, as a screening method, the 4-chamber view has good sensitivity. Additional views are necessary to image the great vessels and detect lesions such as transposition of the great arteries and tetralogy of Fallot (Figure 2).

(2) ***Doppler ultrasound:*** Abnormal patterns of fetal blood flow, including valvular stenosis and insufficiency can be detected reliably by fetal Doppler echocardiography. Pulsed Doppler in the left ventricular outflow tract (using mitral inflow and aortic outflow) also is very useful in assessing arrhythmias and atrioventricular association.

(3) ***M-mode echocardiography.*** M-mode allows accurate measurement of ventricular sizes and function and timing of atrial and ventricular contractions when assessing arrhythmias.

SUMMARY:

In summary, congenital heart disease is the most frequently encountered congenital anomaly. In selected cases, fetal echocardiography provides anatomic and physiologic data which is valuable for detection of congenital heart anomalies. Information gained from fetal echocardiograms is useful in planning care both for the mother and for the fetus.

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ASK A LAWYER

1. What types of conduct by a physician may result in disciplinary action by the State of Nebraska?

A license to practice a profession in the State of Nebraska may be denied, revoked, suspended, or have other disciplinary measures taken against it when the holder is guilty of any of the following:

1. Fraud or forgery, in procuring a license;
2. Grossly immoral or dishonorable conduct;
3. Habitual intoxication or dependency on drugs;
4. Conviction of a misdemeanor or felony related to one's capacity to practice the profession;
5. Practicing fraudulently, beyond its authorized scope, with manifest incapacity, or with gross incompetence or negligence;
6. Practicing while impaired by alcohol, controlled substances, or physical, mental, or emotional disability;
7. Physical or mental incapacity to practice the profession as evidenced by a legal adjudication.
8. Permitting, aiding, or abetting the practice of a profession by a person not licensed to do so;
9. Having had his or her license disciplined by another state;
10. Unprofessional conduct including, but not limited to:
    a. Violation of the ethics of the profession;
    b. Solicitation of professional patronage by agents or persons, popularly known as cappers or steerers;
    c. Receipt of fees on the assurance that a manifestly incurable disease can be permanently cured;
    d. Division of fees with any person for bringing or referring a patient;
    e. Obtaining any fee by fraud, deceit, or misrepresentation, including falsification of third party claim documents;
    f. Cheating on the licensing examination;
    g. Assisting in the care or treatment of a patient without the consent of such patient or the legal representative;
    h. Use of terms on stationery, etc., indicating that one practices that for which one is not licensed;
    i. Performing, procuring, or aiding and abetting in the performance or procurement of a criminal abortion;
    j. Willful betrayal of a professional secret except as otherwise provided by law;
    k. Use of any advertising statements to deceive the public;
    l. Advertising professional superiority;
    m. Advertising to perform any service painlessly;
    n. Performance of an abortion without being available for a period of at least 48 hours of post-operative care;
    o. Performing an abortion upon a minor without satisfying notice requirements;
    p. Sexual stimulation by a massage therapist;
    q. Violation of an assurance of compliance;
    r. Any act of sexual abuse, misconduct, or exploitation related to the practice of the profession;
    s. Failure to keep adequate records of treatment or service;
    t. Prescribing, giving, or selling any controlled substance for other than a medically accepted therapeutic purpose;
    u. Administering any controlled substance to oneself or, except in an emergency, to one's spouse or child; and
    v. Such other acts adopted by the Board of Examiners.
11. Use of untruthful or exaggerated claims, concerning such licensee's professional abilities, in advertisements;
12. Violation of the Uniform Deceptive Trade Practices Act;
13. Distribution of liquor or drugs for unlawful purposes;
14. Violations of the Uniform Licensing Law or of professional, sanitation, quarantine, or school inspection rules;

15. Unlawful practice of any profession without a license;
16. Violation of statutes relating to birth and death certificates;
17. Violation of the Uniform Controlled Substances Act; or
18. Violation of the Wholesale Drug Distributor Licensing Act.

2. What is the hearing process for disciplinary actions?

Any person may complain to the Department of Health of an alleged violation of licensure laws with respect to the above-named conduct, and request an investigation. The physician may or may not be notified of the complaint and investigation depending on the Department's determination that such notice may prejudice the investigation. The complainant may request that the Department of Health not release his or her identification to the Board of Examiners. The Department will determine whether to conduct an investigation based on such factors as whether the matter is within the Department's authority to enforce, whether the complaint is made in good faith and not malicious, whether the complaint is timely, whether the complainant is willing to identify himself or herself if he or she will be a necessary witness, and whether information within the complainant's knowledge provides a reasonable basis to believe the violation occurred.

If the Department does not pursue an investigation, the complainant will be notified and may request that the Board of Examiners review the complaint and recommend whether the complaint should be investigated. If an investigation is pursued, the Department will then consult with the Board of Examiners who issue a recommendation to the State Attorney General. The Attorney General has the ultimate determination of which, if any, laws have been violated, and of what legal action should be taken.

If the Attorney General files a petition for disciplinary action with the Director of Health, notice of a hearing is given to the licensee at least ten days in advance. The matter may be settled by an agreement between the parties at any time before the Director of Health enters his/her order. The Attorney General may not enter into a settlement or dismiss any petition without first seeking input from the Board of Examiners. If not settled, a hearing officer reports his findings from the hearing to the Director of Health who finally resolves the issue.

The parties may then appeal the Director of Health's determination to the District Court in the county where the action was taken.

3. What are the range of penalties in disciplinary cases?

The Attorney General has the options of filing a petition for disciplinary action with the Director of Health, as described above, negotiating a voluntary surrender or limitation with the physician, or, in cases involving a technical or insubstantial violation, sending to the licensee a letter of concern and requesting in return an assurance of compliance signed by the physician.

If a petition is filed for disciplinary action with the Director of Health, upon the completion of the hearing, the Director has the authority to order any or all of the following:

1. Issue a censure or reprimand against the licensee;
2. Suspend judgment;
3. Place the licensee on probation;
4. Place limitations on the right of the licensee to practice the profession under such conditions as are deemed proper;
5. Impose a civil penalty not to exceed $10,000.
6. Suspend the license;
7. Revoke the license;
8. Dismiss the action.

There is no applicable statute of limitations which may bar disciplinary action by the State of Nebraska against a physician. The patient, of course, has the additional options of pursuing other legal remedies against the physician, independent of these licensing laws and independent of any complaint which they have filed with he Department of Health.

*Responses found in this "Ask A Lawyer" column do not reflect any amendments by the 1994 Nebraska Legislature.

***

"Ask a Lawyer' is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the Nebraska Medical Journal. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen, with the assistance of UNL College of Law student Jane Kemper of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

WELCOME NEW MEMBERS

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Carol A. Kunke, ,M.D.
Our Lady of Lourdes Hospital
1500 Koenigstein
Norfolk, NE 68701

John W. West, M.D.
2101 Lincoln Ave.
York, NE 68467

COMING MEETINGS

CREIGHTON UNIVERSITY

JUNE 25, 1994 — Medical Presentation Skills Conference - St. Joseph Hospital Seminar Room, Omaha, NE.

JUNE 29, 1994 — Couple to Couple League - "Natural Family Planning: The Time Has Come" - St. Joseph Hospital, Omaha, NE.

JULY 27, 28, 1994 — Third Annual Conference: Current Concepts in Sub-Acute Care, Defining The Difference, Marriott Hotel, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

SEPTEMBER 29, 1994 — Ultrasonography - Marriott Hotel - Omaha, NE.

SEPTEMBER 30 - OCTOBER 1, 1994 — Day With the Perinatologists - Marriott Hotel, Omaha, NE.

OCTOBER 4, 1994—T.T. Smith Lecture, BTNRHA.

OCTOBER 7, 1994 — Fifth Annual: Come Home to Creighton, Skutt Student Center, Creighton University, Omaha, NE.

OCTOBER 19, 1994 — Distinguished Lecture Series, William J. Hoskins, M.D.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 2500 California Street, Omaha, NE 68178.

MAYO FOUNDATION

SEPTEMBER 12-14, 1994 — The Norwegian-American Orthopaedic Society, Program site: Rochester, MN.

SEPTEMBER 23-24, 1994 — The Lower Extremity Amputee: A Multidisciplinary Approach, Mayo Foundation, Rochester, Minnesota, Registration fee: $300, 15 credit hours in Category I AMA.

OCTOBER 15-16, 1994 — International Symposium on Myeloproliferative Disorders, Program Site: Rochester, MN.

OCTOBER 23-27, 1994 — Advances in Diagnostic Radiology, The Cloister, Sea Island, Georgia. Registration fee: $595, 22.5 credit hours in Category 1 AMA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

SEPTEMBER 15-17, 1994 — Fall Session, Cornhusker Hotel, Lincoln.

APRIL 27-30, 1995—Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

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For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuing Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

MONDAY - TUESDAY, SEPTEMBER 12-13, 1994 — Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

SATURDAY, SEPTEMBER 17, 1994 — 7th Annual Internal Medicine Update, University of Nebraska Student Union, Lincoln, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER, Fee: $45.

MONDAY, SEPTEMBER 26 — SATURDAY, OCTOBER 1, 1994 — Emergency Medicine, 1994, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

FRIDAY AFTERNOON, OCTOBER 7, 1994 — University of Nebraska College of Medicine Alumni Day (in conjunction with the Omaha Midwest Clinical Society Meeting), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: College of Medicine Alumni.

FRIDAY EVENING - MONDAY, OCTOBER 14-17, 1994 — Advanced Curriculum on Women's Health - Part II, Adam's Mark, Philadelphia, Pennsylvania, Target Audience: Primary Care Physicians.

SATURDAY, OCTOBER 22, 1994 — Evaluation and Management of the Swollen Extremity, Red Lion Hotel, Omaha, Nebraska, Target Audience: Primary Care Physicians.

For further information: Contact the Center for Continuing Education, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-5651. Call (402) 559-4152 or use our toll free MD Advantage Number and ask for Continuting Education (800) 642-1095 Nationwide, FAX Number (402) 559-5915.

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

FRIDAY-SUNDAY, JUNE 24-26, 1994 — Frontiers In Endourology, Location: Washington University Medical Center, St. Louis, Missouri, Program Chairman: Ralph V. Clayman, M.D.

For further information on any of the above seminars contact: Continuing Medical Education, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Avenue, St. Louis, Missouri, 63110-1093, (800) 325-9862.

1994 Nebraska Medical Association 50-Year Practitioners

PAUL G. GOETOWSKI, M.D.
- Walton -

Paul G. Goetowski was born in Fitchburg, Massachusetts on August 23, 1915. He obtained his medical education at the Creighton University School of Medicine. Following service in the U.S. Navy, Dr. Goetowski took orthopedic residencies at the Veterans Administration Medical Center in Lincoln and Tulane University Medical School in New Orleans. Upon completing his residencies, Dr. Goetowski re-entered the navy for an additional years service. He began his practice of orthopedic surgery in Lincoln in 1952. Dr. Goetowski continues his practice in Lincoln at the Veterans Administration Medical Center.

BARNEY B. REES, M.D.
- Omaha -

Barney B. Rees was born in Pueblo, Colorado on July 7, 1917. He obtained his medical education at the University of Nebraska College of Medicine. He completed his internship and a year of surgical residency at Clarkson Hospital in Omaha. Following service in the U.S. Army, Dr. Rees completed his residency at the University Hospital in Omaha. Dr. Rees practiced general surgery in Omaha until his retirement. He was awarded Life Membership in 1988.

WARREN G. BOSLEY, M.D.
- Grand Island -

Warren G. Bosley was born in Palisade, Nebraska on January 1, 1922. He obtained his medical education at the University of Nebraska College of Medicine and interned at the Johns Hopkins Hospital in Baltimore, Maryland. Following two years service in the U.S. Army, Doctor Bosley completed a residency in pediatrics at the Babies Hospital in New York City. He practiced pediatrics in Grand Island from 1956 until 1991 and is currently practicing at the Hastings Regional Center. Dr. Bosley served as president of the Nebraska Medical Association in 1975-76.

JOHN H. COE, M.D.
- Omaha -

John D. Coe was born in Hastings, Nebraska on November 11, 1918. He obtained his medical education at the University of Nebraska College of Medicine. Dr. Coe interned at the Boston City Hospital and took his residency at the Beverly Hospital in Beverly, Massachusetts. Following two years service in the U.S. Air Force, Dr. Coe returned to Omaha and completed surgical residencies at the University Hospital and Clarkson Hospital. Dr. Coe practiced general surgery in Omaha and served as president of the Nebraska Medical Association in 1973-74. He was a Nebraska Medical Association alternate and delegate to the American Medical Association House of Delegates from 1979 through 1992. Dr. Coe was awarded Life Membership in 1990.

RALPH L. CASSEL, M.D.
- Omaha -

Ralph L. Cassel was born in Montrose, Colorado on August 27, 1920. He obtained his medical education at the University of Nebraska College of Medicine and interned at the U.S. Naval Hospital in San Diego, California. Dr. Cassel served in the U.S. Navy in 1945-46 and again in 1953-54. He practiced as a general practitioner in Fairbury from 1946-1978. Dr. Cassel joined the faculty at the University of Nebraska Medical Center in 1978 and practiced there until his retirement in December, 1986. Dr. Cassel was awarded Life Membership in 1987.

STANLEY M. TRUHLSEN, M.D.
- Omaha -

Stanley M. Truhlsen was born in Herman, Nebraska on November 13, 1920. He obtained his medical education at the University of Nebraska College of Medicine and interned at the Albany Hospital in Albany, New York. Following two years service in the U.S. Army, Dr. Truhlsen took his residency in ophthalmology at Barns Hospital in St. Louis, Missouri. He practiced ophthalmology in Omaha until his retirement in 1993. Dr. Truhlsen served as Chairman of the Nebraska Medical Association Board of Councilors from 1981-1987.

1994 Nebraska Medical Association 50-Year Practitioners

LELAND J. OLSON, M.D.
- Omaha -

Leland J. Olson was born in Palmyra, Nebraska on October 3, 1920. He obtained his medical education at the University of Nebraska College of Medicine. Dr. Olson completed his residency at the University Hospital in 1949. He practiced obstetrics and gynecology in Omaha until his retirement in 1986. Dr. Olson has established a Chair of Clinical Investigation in OB/Gyn, a Resident Research Fund and the Olson Center for Women's Health at UNMC. Dr. Olson was awarded Life Membership in 1986.

WILBERT E. HEIB, M.D.
- Henderson -

Wilbert E. Heib was born in Marion, South Dakota on August 1, 1920. He obtained his medical education at the University of South Dakota and the Washington University Medical School in St. Louis, Missouri. Dr. Hieb took a general internship and residency at the Evangelical Deaconess Hospital in St. Louis. Following two years service in the U.S. Army, he established a solo general practice in Marion, South Dakota where he practiced until 1954. In 1954 he joined the Henderson Clinic at Henderson, Nebraska where he practiced until his retirement in 1984. Dr. Hieb was awarded Life Membership in 1985.

MERRILL T. EATON, M.D.
- Omaha -

Merrill T. Eaton was born in Howard County, Indiana on June 25, 1920. He obtained his medical education at the Indiana University School of Medicine in Indianapolis and interned at St. Elizabeth's Hospital in Washington, D.C.. Following two years service in the U.S. Army, Doctor Eaton completed residencies at Colorado State Hospital in Pueblo and Sheppard-Pratt Hospital in Towson, Maryland. Dr. Eaton practiced psychiatry in Kansas City, from 1949-60. He became an Associate Professor of Psychiatry at the University of Nebraska College of Medicine in 1961 and served as Professor and Chairman of the Department of Psychiatry at UNMC from 1968 to 1985. Dr. Eatson was awarded Life Membership in 1989.

Also recognized for 50 years of medical practice but unable to attend the Annual Session were:

EDWARD K. CONNORS, M.D.
- Omaha -

RICHARD J. FANGMAN, M.D.
- Omaha -

PAYTON T. PRATT, M.D.
- Omaha -

CHARLES M. ROOT, M.D.
- Ft. Myers Beach, Florida -

WILLIAM L. RUMBOLZ, M.D.
- Omaha -

JACK M. STEMPER, M.D.
- Lincoln -

JOHN G. WIEDMAN, M.D.
- Lincoln -

PHOTO GALLERY

Nebraska Medical Association

1994 Annual Session

Dr. Frederick Paustian presents Dr. Ralph Cassel with a certificate honoring him for fifty-years of medical practice.

Dr. Charles Damico presiding at the Board of Councilors' meeting.

Dr. Frederick Paustian presents Dr. John Coe with a certificate honoring him for fifty-years of medical practice.

NMA Honors Luncheon.

Dr. Frederick Paustian presents Dr. Merrill Eaton with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Warren Bosley with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Paul Goetowski with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Wilbert Heib with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Leland Olson with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Barney Rees with a certificate honoring him for fifty-years of medical practice.

Dr. Frederick Paustian presents Dr. Stanley Truhlsen with a certificate honoring him for fifty-years of medical practice.

Dr. Robert Shapiro presents Dr. Carl Cornelius a plaque recognizing his service as an alternate and delegate to the American Medical Association House of Delegates.

Dr. Darroll Loschen presenting the necrology.

Dr. Robert Shapiro, 1993-94 NMA President, addressing the House of Delegates.

Ms. Mary Dean Harvey, Director, Department of Social Services, adressing the House of Delegates.

NMA lobbyist and legal counsel David Buntain addressing the House of Delegates

Reference Committee in session.

Dr. Tim Wahl, Chairman, Nebraska Medical Political Action Committee, addresses the House of Delegates.

Reference Committee in session.

Dr. Thomas Cinque, Dean, Creighton University School of Medicine, addressing the House of Delegates.

Reference Committee in session

Dr. Mark Horton, Director, Department of Health, addressing the House of Delegates.

Inaugural Dinner

Doctor John Sage serving as master of ceremonies for the 1994 Inaugural Dinner.

Dr. Frederick Paustian accepting the President's medallion from Dr. Robert Shapiro.

Sally Semm, 1994-95 NMAA President, presenting inaugural remarks.

Dr. Robert Shapiro pins the President's badge on Dr. Paustian.

Dr. Frederick Paustian, 1994-95 NMA President accepting the President's gavel from Dr. Robert Shapiro, 1993-94 NMA President.

Dr. Frederick Paustian presents a plaque for outstanding service as President to Dr. Robert Shapiro.

Dr. Robert Shapiro presents Dr. Frederick Paustian with the "It's Only a Pumpkin" plaque.

Dr. Frederick Paustian pins the Past President's badge on Doctor Robert Shapiro

Dr. Frederick F. Paustian, 1994-95 NMA President, presenting his inaugural address.

Susan Schwerdtfeger accepts the McWhorter Memorial Scholarship from Doctor Blaine Roffman.

C. Randall Nelms, M.D., President, Minnesota Medical Association, addressing the House of Delegates.

Renee Woehrer accepts the Tanner Memorial Scholarship from Dr. Robert Shapiro.

Barbara Bohi, 1993-94 NMA Alliance President, addressing the House of Delegates.

Dr. Robert Shapiro presenting an NMA research scholarship to Thomas Sullivan, University of Nebraska College of Medicine.

Ashok Gupta accepts the NMF/LCMAF Research Scholarship from Mrs. Kay Reed.

Dr. Robert Shapiro, 1993-94 NMA President, accepts a plaque from Dr. James Fosnaugh recognizing his service to the Lancaster County Medical Society.

Dr. Eugene Zweiback presents the report of Reference Committee #1.

Dr. John Reed presents the report of Reference Committee #5.

Dr. James Fosnaugh presents the report of Reference Committee #2.

Dr. Edward Holyoke, Jr. presents the report of Reference Committee #6.

Dr. Gordon Adams presents the report of Reference Committee #3.

Dr. Charles Damico presents the report of the Nominating Committee.

Dr. Allen Dvorak presents the report of Reference Committee #4.

Dr. Frederick Paustian presenting Dr. David Bacon with the President-Elect badge.

NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

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PHYSICIAN'S DIRECTORY

The Physicians' Directory is intended to assist our readers in the referral process and you are encouraged to so utilize it. Directory space is sold in one-eighth page multiples for a twelve-month period. Detailed information regarding content and cost can be obtained through the Nebraska Medical Association office, 233 So. 13th St., Suite 1512, Lincoln, Nebraska 68508, phone (402) 474-4472.

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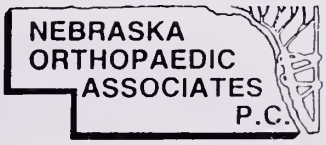

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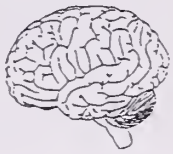

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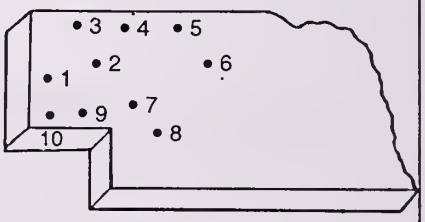

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Frederick F. Paustian, M.D.

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Due to a production error in the May, 1994 issue, this article is being reprinted in its entirety. We apologize for the inadvertent deletion of text.

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COVER PICTURE
"SUMMER SPECTACULAR"
Photography by Stuart P. Westburg, M.D.
Lincoln, Nebraska

PHOTOGRAPHERS & ARTISTS:
Pictures wanted for front cover of the Nebraska Medical Journal. Vertical format prints of subjects typical of Nebraska preferred, but horizontal pictures can be modified as necesssary. Mail to Stuart P. Westburg, M.D., 2756 O Street, Lincoln, NE 68510.

PRESIDENT'S PAGE

Health Care Fraud and Abuse - Revisited

FREDERICK F. PAUSTIAN, M.D.

The Nebraska Medical Association House of Delegates, in its September, 1993 Fall Session, adopted the following resolution:

Whereas, we recognize that fraud and abuse can exist in medically related government programs, and

Whereas, that fraud and abuse can exist across the spectrum of the medical system, and

Whereas, physicians share an ethical and moral responsibility to report potentially fraudulent activities;

Therefore, be it resolved that the Nebraska Medical Association and component societies support and assist in programs designed to curb such fraud and abuse where it might occur.

What is the problem?

The magnitude of dollars lost as a consequence of health care fraud cannot be quantified, only estimated, and such estimates vary widely. The FBI Health Care Fraud Unit in 1992 estimated the loss to be more than $33 billion and in the same year the U.S. General Accounting Office, citing health insurance industry sources, estimated the loss to be 10% of the nation's total annual health care expenditure, which, according to the U.S. Department of Health and Human Services, in 1992 was over 800 billion dollars. Therefore, Attorney General Janet Reno is making health care fraud her second priority after violent crime and the FBI is making it their number one investigative priority in their white collar crime program. It is very important for we, as physicians, to be fully aware of what constitutes health care fraud and abuse in order that we may recognize it and report such crime to the proper authorities. Suspected incidents may be reported to our respective county medical societies; the Nebraska Medical Association; Director of the Department of Health, State of Nebraska, in Lincoln, Nebraska; The Sunderbruch Corporation of Nebraska in Lincoln, Nebraska; the FBI office in Omaha, Nebraska; and the Health

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Care Financing Administration of the Department of Health and Human Services in Kansas City, Missouri.

What constitutes fraud and abuse? According to Medicare and Medicaid, these terms are defined as follows:

"Provider Fraud" - Fraud is an intentional deception or misrepresentation with the intent to illegally obtain services, payments or other gains. Examples include:

- Billing for services not rendered.
- Billing for more costly services than rendered (upcoding).
- Falsifying medical or billing records to obtain greater reimbursement.
- Billing more than the charge to the general public.
- Billing for services provided by unqualified or unlicensed personnel.
- Receiving kickbacks from medical providers for referrals or use of products as laboratory tests, medications, DME, etc.
- Routine lack of intent to collect deductible or co-insurance amounts on claims.

"Provider Abuse" - Abuse exists when providers or suppliers methods or business practices are unacceptable and result in an incorrect payment for services rendered or involve pat-

terns of over utilization or misutilization of services without demonstrated intent or false statement. Examples:

- A Medicare participating doctor does not accept assignment on a claim.
- Billing a different amount to Medicare than to patient.
- Collecting more than the allowed deductible or co-insurance amounts on an assigned claim.
- Rendering or ordering excessive services, especially diagnostic tests.
- Providing services that are inconsistent with the diagnosis and treatment of recipient.
- Rendering or ordering medically unnecessary services.
- Poor or unsatisfactory quality of care provided to a recipient.

The potential consequences of Medicare and Medicaid fraud and abuse include:

- Criminal investigation and/or prosecution by the Office of Inspector General and/or the FBI.
- Civil monetary penalties (up to $2000 per false item).
- Exclusion from provision of Medicare and/or Medicaid services permanently or for a period of time.
- Referral to a professional licensing board.
- Restitution of Medicare or Medicaid overpayment.
- Peer review referral.
- Attendance at provider education sessions.

The Federal Bureau of Investigation's health care fraud initiative (available on request from the office of the Nebraska Medical Association) indicates their principal goal is to bring the same aggressive approach to health care fraud as the Bureau used successfully in other priority programs such as organized crime, counter terrorism, and political corruption. Sophisticated investigative techniques to combat health care fraud include undercover operations, telephone intercepts, aggressive use of informants, and cooperating witnesses. (In addition, new computer technology utilizes IBM developed software, Fraud and Abuse Management System (FAMS), currently implemented by Pennsylvania Blue Shield.) The majority of investigations are conducted jointly with one or more other governmental agencies. As a consequence, during 1993 FBI health care fraud investigations increased from 657 to 1,051 and convictions rose from 115 to 327. The jurisdiction of the FBI is not limited to Medicare and Medicaid but also includes private pay systems. The categories of health care under surveillance include durable medical equipment, psychiatric hospital, clinic - especially diet clinics, pharmaceutical diversions, pharmacy billing, physician practice associated or related activities, laboratory services, workers compensation and accident claims, nursing home and hospital services, and home health care and ambulance services.

The recognition of and potential for health care fraud and abuse is given specific consideration in President Clinton's Health Security Act, HR 3600. The American Medical Association's position regarding Health System Reform: "Health Care Fraud and Abuse," was presented by our Jerald R. Schenken, M.D. to multiple committees and subcommittees of the United States House of Representatives on March 17, 1994 (also available through the office of the Nebraska Medical Association). Excerpts from Dr. Schenken's testimony include the following:

"Fraudulent and abusive schemes . . . lead to the rendering of medically unethical or potentially harmful testing as well as inaccurate, misleading and false diagnoses. Such practices undermine health care delivery, generate unnecessary fear, and increase the already high cost of health care." Accordingly, the AMA agrees with the General Accounting Office recommendation, May 1992, calling for the establishment of a national commission to develop comprehensive solutions to fraud and abuse and advocate a nationally coordinated effort to combat such fraud and abuse.

The AMA recommends modification of the Health Security Act fraud and abuse provisions to include the creation of a clearing house, incorporating standards for the protection of confidential information, which would be utilized to detect fraudulent activity. All health insurance plans would be required to provide information essential to fraud investigations.

As regards the conduct of investigation, it is the AMA's position that coordination of federal antifraud activities be delegated to the U.S. Attorney General rather than the HHS Inspector General. The Department of Justice, especially the Federal Bureau of Investigation, possesses unique and demonstrated experience in orchestrating the law enforcement efforts of various federal, state, and local agencies. This recommendation is based on the conviction

that success of an all payor fraud and abuse control program is contingent upon empowerment of the government agency with the greatest breadth of experience in law enforcement.

While it is recognized that physicians are responsible for their respective actions, it is important to determine whether or not a physician is acting with the intent to commit a fraudulent act as opposed to inadvertent error before the courts impose a severe sanction. Therefore, there should be provisions to preclude harsh sanctions for inadvertent or legitimate mistakes such as billing errors and penalties, should one be imposed, commensurate with the offense committed. Physicians should not be excluded from provision of health care unless a criminal conviction has been obtained.

In the area of physician ownership and self referral, a new category of fraud and abuse, the AMA agrees in principle that physicians should not refer patients to a health care facility outside of their office practice where they do not directly provide care or services, but do have an invested interest. The proposed self referral limitations, however, are very restrictive and exceptions to the prohibition must be permitted where there is demonstrated need in an under-served urban or rural community for the facility and alternative financing is not available. The acceptance of ethical requirements as proposed by the AMA and the formal guidelines developed by the AMA Council on Ethical and Judicial Affairs should resolve the conflict of interest issue associated with physician investment in health care facilities located in the area of the doctors practice.

While the AMA supports the concept that kickbacks, bribes, and rebates in return for medical referral services constitute a criminal violation, safe harbors must be identified wherein incentives are necessary for the recruitment and retention of physicians to provide health care benefits to patients. An example includes incentives to physicians to practice in underserved areas.

Of concern to the medical profession has been the unreasonable constraints placed on professional self regulation as a consequence of state and federal anti-trust laws which inhibit the ability of organized medicine to assume a professional self-regulatory enforcement role. As a consequence of a petition filed by the AMA with the Federal Trade Commission in 1992 concerning these constraints, the FTC issued an advisory opinion which permits professional peer review of physician's fees so long as the disciplinary process is limited to abusive practices. Patient grievance committees acting in an advisory fashion and rendering non-binding decisions are also permissible. Furthermore, the opinion stated that the anti-trust laws do not preclude professional groups from protecting patients by disciplining group members who have engaged in abusive conduct such as fraud, intentional provision of unnecessary services or exercise of undue influence over a vulnerable patient. The FTC opinion represents an important first step in resurrecting the constructive self-regulatory activities of professional societies and patient grievance committees. It is believed that carefully designed legislative immunity from federal anti-trust laws for medical self discipline can enable the medical profession to play a more active role in the elimination of health care fraud and abuse.

In review of the above relaxation of constraints on self regulation by organized medicine and in the past few years identification of multiple alleged instances of improper conduct of practice and/or management of controlled substances by physicians, it is deemed appropriate to restate the following Nebraska State Health and Welfare statutes concerning unprofessional conduct as enacted in LB 536, 1993.

Sec. 45. 71-148 "Unprofessional conduct" - Shall mean any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation . . . including but not limited to:

17. Commission of any act of sexual abuse, misconduct or exploitation related to the practice or the profession or occupation of the applicant, license, certificate holder or registrant;

18. Failure to keep and maintain adequate records of treatment or service;

19. Prescribing, administering, distributing, dispensing, giving or selling any controlled substance or other drug recognized as addictive or dangerous for other than a medically accepted therapeutic purpose;

20. Prescribing, administering, distributing, dispensing, giving or selling any controlled substance or other drug recognized as dangerous or addictive to one-

self, or, except in the case of a medical emergency, to one's spouse or child;

In addition, under Crimes and Punishments Drugs and Narcotics it is stated: 28-411. Controlled substances; records; by whom kept; contents.

1. Every physician, dentist, podiatrist, veterinarian, or other person who is authorized to administer or professionally use controlled substances shall keep a record of such controlled substances received by him or her and a record of all such controlled substances administered or professionally used by him or her otherwise than by prescription.

4. The form of record shall be prescribed by the Department of Health of the State of Nebraska. The record of controlled substances received shall in every case show:

   a. The date of receipt;
   b. The name and address of the person from whom received;
   c. The kind and quantity of controlled substances received, etc.

As the degree of scrutiny under the auspices of quality of care increases, it is of paramount importance that we as physicians maintain accurate and detailed records of our provision of medical care including medications, especially controlled substances.

Because of the breadth and severity of the problem of health care fraud and abuse and its impact upon the quality of medical care and the cost of medical services, it is very important that the physicians of our state, the Nebraska Medical Association and its constituent societies, and the NMA House of Delegates and Board of Directors give serious consideration to enhancement of methods for self regulation and increased interaction with appropriate government and law enforcement entities to more effectively combat the problem. Through such activity there can be an anticipated improvement in the quality of health care and a marked enhancement of the image of physicians in the eyes of the public.

ORIGINAL ARTICLE

What Is The Current Status Of Management Of The Patient With Exercise-Induced Asthma?

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SUMMARY

EXERCISE-induced asthma (EIA) is a very common and troublesome disease frequently impairing optimal athletic performance. Although described as early as the second century A.D. and widely known since 1972, EIA often goes unrecognized by both patient and physician. The goals of treatment are to minimize symptoms thus allowing the athlete to participate fully in a broad array of activities and to utilize the most effective pharmacologic drugs available.

The recognition and treatment of exercise-induced asthma (EIA) have made significant progress since 1972 when United States swimmer, Rick Demont had his Olympic gold medal award rescinded because of traces of ephedrine were detected in his urine. Lessons from this episode paid dividends subsequently; in preparation for the 1984 Olympic games in Los Angeles, the U.S. Olympic Committee developed a screening program which identified 67 U.S. team members with EIA.[1] Astoundingly, several of these world-class athletes did not realize they had asthma. Affected individuals were counseled on the prevention of asthma and also on the effective use of medications; 41 won medals in various competitions including track and field, wrestling, basketball, cycling, swimming and rowing.[2] Despite this resounding success, many athletes at all levels of competition still suffer from unrecognized or undertreated EIA despite knowledge of the problem since the second century A.D. (Areatus the Cappadocian) and possibly since antiquity (Huang-Ti, the Yellow Emperor; 2698-2598 B.C.). Often the signs and symptoms of bronchospasm are subtle and the athlete is frequently unaware of any pulmonary disease. A sensation of shortness of breath, chest tightness, coughing, chest discomfort or pain may be all that is experienced.[3] Adults typically think that they are "winded" or "out of shape". In children, coughing or lack of endurance may be typical features. In any event, neither the patient nor the parent(s) may be aware of any breathing abnormality. Some ignore the symptoms since they usually resolve within a few hours. Often, the examining physician fails to ask the appropriate questions which might reveal the existence of EIA.

During exercise, the bronchioles dilate in both non-asthmatics as well as asthmatic patients. However, in the post-exercise period, airway narrowing significantly reduces pulmonary function in persons with EIA. Exercise-induced asthma is generally defined as a 15% or greater decline in FEV_1 or PEFR occurring maximally at three-fifteen minutes after strenuous exercise. Some athletes also experience "late phase" bronchospasm four-eight hours after initial activity.[4,5] EIA is influenced by the intensity, duration, type and conditions under which exercising occurs.[6,7] The latter is particularly influenced by cold dry air, air pollution, concurrent viral infections and/or allergens. The precise mechanism(s) causing EIA are still a subject of on-going debate;[8,9,10,11] however, four important factors appear to be involved: 1. Respiratory tract water loss with increase in local tissue osmolarity. 2. Respiratory heat loss with resultant bronchial vascular bed dilation. 3. Mediator release from mast cells and basophils through exercise mediated mechanisms. 4. Parasympathetic mediation through vagus nerve innervation. Discussions of these mechanisms and testing procedures are reviewed elsewhere.[12,13]

TREATMENT OF EXERCISE-INDUCED ASTHMA

Before treating EIA, both the patient and the physician must be aware of its' occurrence in the patient. A high clinical suspicion and appropriate measurement of pulmonary function after exercise challenge are helpful in diagnosing EIA. Counseling regarding prevention, and the proper use of medications must be aimed primarily at the patient, but teaching should also be expanded to include parents and coaches. While it appears obvious, one cannot treat an

undiagnosed disease; and further, the importance of patient/parent/coach teaching cannot be overemphasized if compliance is to be assured. Many medications end up unused because of poor instructions, poor directions, ignorance or poor compliance. Additionally, preventive measures while often appreciated, frequently get the short-shrift in the urge to prescribe different or new medications. Avoidance of irritants, tobacco smoke and allergens may decrease airway reactivity thus decreasing the severity of symptoms and lessening the need for excessive pharmacologic agents.[6,7]

PHARMACOLOGIC THERAPY

A wide variety of drugs have been used in the treatment and prevention of EIA (Table I). Many newer drugs are being evaluated (Table II), nevertheless the beta-2 specific agonists are still the most effective agents currently available.[14,15,16,17] In the United States, albuterol, terbutaline, pirbuterol and bitolterol are extensively used replacing older and less beta-2 specific drugs such as metaproterenol, isoproterenol and isoetharine (all banned by the International Olympic Committee; Table III). A number of effective beta-2 agonists including fenoterol, procaterol, rimetrol and clenbuterol[15] are available in Europe and elsewhere, but are not yet available in the United States, Albuterol (Ventolin®, Proventil®), terbutaline (Brethaire®), pirbuterol (Maxair®) and bitolterol (Tornalate®) are the most effective agents currently available and when given by aerosol 10-60 minutes before exercise, they will prevent bronchospasm for as long as three to six hours. Delivery by metered dose inhaler (MDI) or nebulizer results in a more rapid onset of action, greater effectiveness and fewer side-effects than if given by the oral route. A spacer device such as InspirEase™ (Schering Corp., Kenilworth, NJ) or an AeroChamber™ (Forrest Pharmaceuticals, St. Louis, MO) may be used in children or in those adults who have difficulty using an MDI. Occasionally, albuterol using a Rotacap™ method can be substituted. Typically, two puffs from an MDI prior to exercise is sufficient to attenuate bronchospasm; occasionally, higher doses (four to six puffs) may be used as greater efficacy and duration of action have been shown; however the incidence of tremors and tachycardia may increase. If the athlete is having acute symptoms, two-four puffs of a beta agonist will abort or attenuate the asthma. Occasionally, an oral beta-2 agonist is given because of convenience or because of the inability to use an aerosol device; it is usually given an hour or so before exercise due to delayed onset of action. In some individuals, the use of a sustained-release beta agonist may be more convenient and also assure better compliance.

Also, frequently used in EIA is cromolyn sodium[18,19] which is administered by metered dose inhaler fifteen-thirty minutes before exercise. While as many as 70% of patients may be protected, the duration of action and effectiveness is generally not as great as with a beta-2 specific agonist.[16] Because cromolyn sodium does not result in bronchodilation and baseline pulmonary function is not improved, the combined use with a beta agonist may be required. Cromolyn sodium has been shown to be as effective as theophylline and calcium channel blockers in preventing EIA. It is more effective than either atropine, ipratropium bromide or ketotofen. In some patients with late-phase asthma reactions, cromolyn sodium has been effective. Further, cromolyn sodium has been shown to be very safe with virtually no known side effects. Therefore, it is often used in children or in patients where problems with beta agonists may exist. The spinhaler device is no longer used because of its' inconvenience and in some patients, the lactose powder in the capsules had an irritant effect on the airways. Occasionally, the combined use of a beta agonist with cromolyn sodium is effective in prolonging the duration of action while decreasing the side effects from the former. Several new or experimental drugs are currently being evaluated (Table II). Nedocromil sodium (Tilade),[20] a drug used in Europe and currently being studied in the United States[2], has been shown to be effective in preventing exercise-induced asthma in adults [18,19] and children.[21] It belongs to the pyronoquinolone family. Other drugs with cromolyn-like activity include lodoxamide, nivimedone, and bufrolin. While these drugs have greater *in vitro* activity than cromolyn, their clinical effectiveness has been limited.

Theophylline[22] has been used in the United States since the 1930's as an anti-asthmatic drug and has been shown to be effective in preventing exercise-induced asthma. While less potent than inhaled beta-2 agonists, the regular, daily use of theophylline may be more effective in preventing EIA than taking a single dose before exercise. The chronic use of theophylline appears to have a potent prophylactic effect and correlation between serum theophylline levels

TABLE I
Pharmacologic agents used to treat exercise-induced asthma.

Drugs	Dose	Comments
Beta-2 agonists:		
Albuterol	2-4 puffs	Highly effective, moderate duration of action, easy to use; available as MDI, Rotacap.
Terbutaline	2-4 puffs	Highly effective, moderate duration of action, easy to use; available as MDI.
Bitolterol	1-2 puffs	Highly effective, long duration of action, less convenient to use; available as MDI.
Pirbuterol*	2 puffs	Highly effective, moderate duration of action, less convenient to use; available as MDI.
Cromolyn sodium	2-4 puffs	Effective, short duration, easy to use, blocks late-phase asthma; available as MDI or spinhaler.
Theophylline (sustained release)	5-12 mg/kg every 12 hrs.	Effective, regular more effective than occasional use before exercise; side effects higher.
Steroids (inhaled)	2-4 puffs	Marginal effects on exercise-induced asthma, beneficial for late-phase reactions; available as MDI.
Ipratropium Bromide	2-4 puffs	Limited use in exercise-induced asthma; available as MDI.

*Not approved by the International Olympic Committee

TABLE II
Experimental drugs in exercise-induced asthma

Cromolyn-like drugs	Comment
Proxicromil	Mildly effective in asthma and EIA: Studies halted because of malignancies in long term animal studies.
Doxanzole	More active than cromolyn *in vitro* but not effective in clinical asthma/EIA.
Cromolyn-like activity with different chemical structures	
Nedocromil	Studies indicate clinical effectiveness in adults and children with EIA.
Lodoxamide	Orally, effective but with significant side effects. Aerosol form somewhat effective.
Bufrolin	Much greater *in vitro* potency than cromolyn, but limited clinical activity.
Antiinflammatory agents and antihistamines	
Astemizole	May be effective in adults in preventing EIA, however studies in children are equivocal.
Terfenadine	Clinical studies indicate some effectiveness in EIA. Not as effective as beta-agonists or other available agents.
Ketotifen	Clinical studies suggest efficacy comparable to theophylline and cromolyn; use in EIA is unclear.
Azatadine	High doses required to prevent EIA and are associated with considerable side effects, thus limited usage.
Clemastine	High doses are required to prevent EIA and are associated with significant side effects, thus limited usage.
Calcium channel blockers	
Verapamil, Nifedipine	Clinical studies suggest some protection against EIA, however less effective than inhaled bronchodilators. clinical use is limited.
Atropine-like agents	
Ipratropium bromide	Quaternary derivative of atropine. Effects on EIA are mixed and controversial.
Steroids	
Budesonide	Clinical studies suggest some protection after prolonged treatment.

TABLE III
Sympathopneumatic agents permitted or banned in Olympic and NCAA competition

US generic name	International name	Proprietary name
Albuterol	Salbutamol	Proventil, Ventolin
Bitolterol	Bitolterol	Tornalate
Terbutaline	Terbutaline	Brethaire
Metaproterenol*	Orciprenaline	Alupent, Metaprel
Rimetrol	Rimetrol	Not available in US

*Letter from physician

Agents Banned

Epinephrine	Metaproterenol
Ephedrine	Pseudoephedrine
Isoproterenol	Phenopropanolamine
Isoetharine	Phenylephrine
Pirbuterol	

and the degree of bronchodilation has been shown. While convenient to administer, theophylline has a narrow therapeutic range and is associated with a number of side effects. Occasionally, the concurrent administration of theophylline with a beta-2 agonist has been advocated; however, the use of these two drugs together may result in increased side effects and may potentiate cardiotoxicity. Therefore, caution is warranted when using the combination of these two drugs in exercising individuals. Research into safer and more effective xanthene-related compounds are under study.

In general, anti-parasympathetic agents have been unpromising.[23] Studies evaluating atropine and ipratropium bromide in EIA have had variable results. Ipratropium bromide is preferred to atropine sulfate because of fewer side effects, however the use of ipratropium bromide is limited in EIA because it requires a near normal pulmonary function baseline.[24]

Other experimental drugs are being evaluated. The cromolyn-like drugs have been studied extensively, however clinical trials have been disappointing. Antihistamines have been shown to be effective in treating asthma[25]; ketotofen, an oral antihistamine, appears to be as effective as theophylline or cromolyn in asthma, however efficacy in EIA is as yet unclear. Studies involving the older antihistamines have suggested some protection against asthma and EIA. However, at therapeutic dosages, effects on bronchospasm are small and high doses are required to induce bronchodilation. However, toxicity precludes their use. Studies involving the newer antihistamines such as astemizole (Hismanal®) and terfenadine (Seldane®) have resulted in conflicting studies. Pierson and his associates[26] have demonstrated that terfenadine in doses of 60, 120, 180 mg. resulted in bronchodilation for as long as four hours. When similar doses were given four hours prior to exercise, bronchospasm was attenuated at two and five minutes post-exercise but there was no difference between placebo and terfenadine beyond 5 minutes after exercise. Similarly, clinical studies with astemizole have been variable. Clee and associates[27] demonstrated a protective effect of 10 mg. of astemizole in adults with EIA. However, in a study by Backer et al[28] astemizole was unable to prevent EIA in twenty children. Clemastine has also been shown to have a protective effect on EIA in adults, however side effects preclude clinical use. It is pertinent to state here that antihistamines did not have an adverse effect on asthma, thus removing a long-held misconception. Nifedipine (20 mg.) and other calcium antagonists taken prior to exercise may provide limited protection. Although they may prevent EIA, they are not as effective as beta-2 specific agonists. Inhaled corticosteroids have very limited effect on exercise-induced asthma and their clinical role is minimal.

CAUTIONS IN DRUG THERAPY

Much has been learned from the sad experience of the U.S. swimmer in the 1972 Munich Olympics. It is particularly important to check when using anti-allergic medications and decongestants since many over-the-counter preparations contain alpha agonists which are banned. An innocuous OTC drug such as Sudafed contains pseudoephedrine which is banned and may result in disqualification of the athlete. Cough medications which contain codeine may be used inadvertently by the athlete and result in disqualification.

TREATMENT STRATEGY

For patients with mild to moderate EIA, inhalation of beta-2 agonists with or without cromolyn will prevent bronchospasm. In the majority of patients, the inhalation of beta-2 specific agonists alone is sufficient to provide attenuation against bronchospasm and permit active participation in competitive and recreational sports. In the athlete with more severe asthma, the regular use of cromolyn sodium together with daily inhaled beta-2 agonists may be required, additionally two to four puffs of a beta agonist before exercise should be used. Efforts at reducing airway irritability and inflammation should be pursued.[29] Decreasing exposure to environmental irritants and allergens are

essential. The use of inhaled or oral steroids may be required for short periods of time. Despite these efforts, some athletes need to be redirected into sports that involve recurrent, short bursts of exercise rather than prolonged, vigorous exercise. For example, activities such as tennis, baseball or volleyball may be better suited for those athletes who have significant problems with EIA rather than engaging in long distance running, competitive bicycling or cross-country skiing. Similarly, athletes engaging in winter sports tend to do better with indoor sports, where humidity and temperature are higher.

NON-PHARMACOLOGIC TREATMENT

CONDITIONING

As far back as the 1500's, conditioning has been prescribed for asthma. The reports in the medical literature suggest that increased physical conditioning diminishes the need for anti-asthmatic medications and reduces the severity and frequency of asthma attacks.[30,31] However, even with optimal conditioning, highly strenuous exercise can provoke EIA in some individuals. Judgement is required.

"REFRACTORY" PERIOD INDUCED BY SHORT BURSTS OF ACTIVITY

Numerous studies have shown that short bursts of repeated physical activity prior to strenuous activity reduce exercise-induced asthma. Schnall and Landau[32] have shown that brief thirty second periods of running separated by short intervals appeared to prevent EIA in a small group of subjects for periods of up to three hours. Reiff and associates[33] demonstrated in a small group of asthmatic subjects, that a thirty minute, low intensity warm-up period prevented EIA from developing when subjected to a standard six-minute high intensity treadmill test twenty minutes later. The physiologic events resulting in the "refractory" period is unknown; however, endogenous epinephrine and/or norepinephrine released during exercise may modify EIA. In some athletes, long distance running enables the athlete to "run through their EIA". The mechanism of this is unknown. While it is important for all athletes to warm-up before engaging in strenuous exercise, it is essential for asthmatics and athletes with EIA. Warm-up exercises should include a minimum of ten-fifteen minutes of lower-intensity exercise.

CONCLUSION

Exercise-induced asthma is underdiagnosed and undertreated. The coach and physician must be particularly alert to the signs and symptoms of EIA.

Prevention and counseling, proper conditioning, proper warm up and participation in sports less likely to provoke EIA together with the appropriate medications allow patients to engage in sports and compete effectively. Beta-2 agonists such as albuterol, terbutaline, pirbuterol and bitolterol are effective in preventing and treating exercise-induced bronchospasm. Cromolyn sodium also has a role in the treatment and prevention of EIA. Newer and more effective drugs such as nedocromil are being evaluated.

Acknowledgment

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ORIGINAL ARTICLE

Burst Fracture Of The Twelfth Thoracic Vertebra In A Middle Aged Man With Osteoporosis

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INTRODUCTION

At least 1.5 million fractures per year are noted secondary to low bone density and deterioration of bone structure.[1] Almost 200,000 vertebral osteoporotic fractures occur annually with a life time risk of 16%.[2] Compression fracture(s) of vertebrae in osteoporotic elderly patients are commonly seen with minimal trauma. However, burst fractures of the vertebral column in young patients are uncommon with a minimal amount of injury and should arouse suspicion of a pathological fracture. The authors narrate a case of a burst/compression fracture of the twelfth thoracic vertebra with incomplete neurological impairment in a middle aged patient with minimal injury.

CASE HISTORY

A 43-year-old white male was riding on a sled being pulled behind a three-wheeler recreational vehicle. He hit a stone, became airborne an estimated 12 inches above the sled, and landed on the ground on his back. He complained of immediate back pain, inability to move or feel his legs and inability to stand or bear weight. He never lost consciousness. Past medical history was remarkable for rheumatic fever and nine previous fractures.

On admission, he was alert and stable hemodynamically. He had tenderness over the thoracolumbar spine without muscle spasm. His motor strength was diminished throughout both lower extremities, especially in both quadriceps and plantar flexors (1/5). Decreased sensation was noted in both thighs anteriorly. Deep tendon reflexes were absent at both knees and diminished (1+/4) at both ankles. Babinski sign was absent. Rectal tone was reduced with sacral sparing.

X-rays (Figures 1 & 2), CT (Figure 3) and MRI of the lumbosacral spine confirmed a burst fracture of the twelfth thoracic vertebra (T12) with a retropulsed fragment of bone and narrowing of the spinal canal to 8 mm at the T12 level compared to 18 mm at the T11 level (45%) canal compromise). There was 65-70% loss of anterior vertebral body height. Cortical thinning and osteopenia were also noted.

He had minimal neurological improvement after 24 hours of mega-dose steroids. The patient then underwent open reduction of the

FIGURE 1
Anteroposterior x-ray of the thoracolumbar vertebrae shows the compression of T11 vertebra with widening of interpredicular distance.

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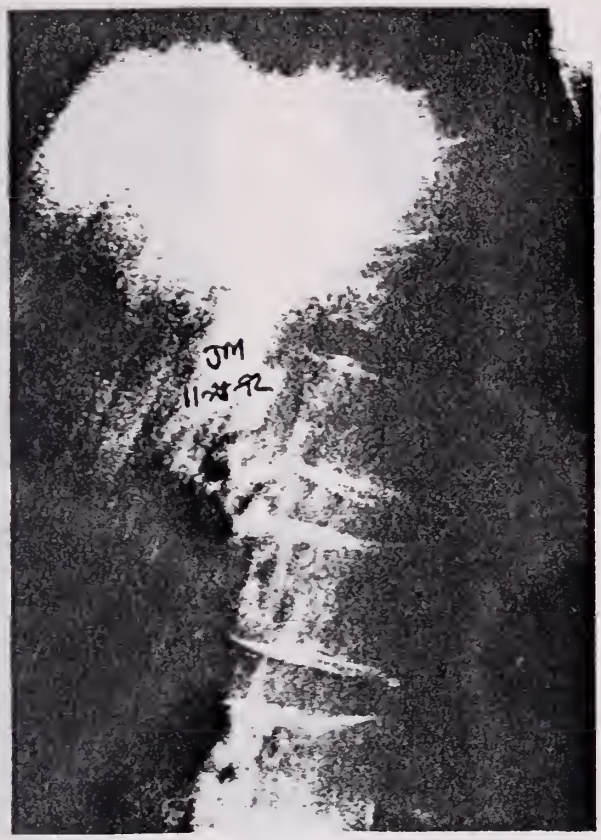

FIGURE 2
Lateral x-ray of the thoracolumbar vertebrae shows the wedge shaped compression of T11 vertebra with decreased anterior body height.

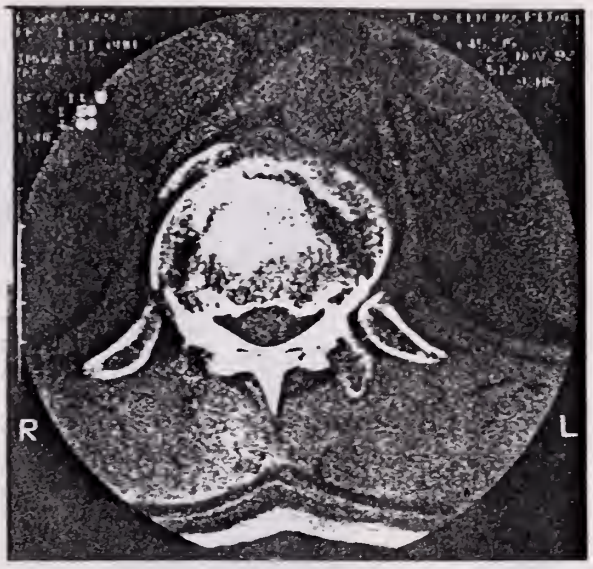

FIGURE 3
Axial CT image through T12 vertebra confirms the burst fracture of the vertebral body and retropulsion of bony fragment compromisting the spinal canal.

burst fracture and of the retropulsed vertebral fragment, segmental fixation of T11, T12 and L1 with pedicle screws and Isola (Acromed, Cleveland, Ohio) rod fixation, augmentation bone grafting of the vertebral body T12 through the pedicles, and bilateral postero-lateral fusion T11 to L1 using autogenous bone grafting from the right posterior iliac crest. Postoperative x-rays showed satisfactory alignment of the vertebral column and rigid internal fixation (Figures 4 & 5). Vertebral osteopenia was also noted at surgery and a bone biopsy was obtained. On the third postoperative day, motor strength improved to 3+/5 in both lower extremities. Sensation to light touch and pin prick returned to normal. Deep tendon reflexes remained absent at both knees and diminished (1+/4) at both ankles. Babinski sign was absent. Rectal tone returned to normal. Straight leg raising (SLR) was without pain at 30^0 on active motion, and at 60-70^0 on passive motion on both sides. On the sixth day his motor strength was 4/5 bilaterally with normal sensation except for some residual numbness in the left T11 dermatome. He was fitted with a thoracolumbar sacral orthosis (TLSO). The patient was allowed out of bed to a chair with a TLSO. He was ambulating very well with a walker in ten days.

Because of the concern about osteopenia in a relatively young patient, an endocrine/metabolic work up was initiated. Bone densitometry revealed a decreased calcium content (70% of the normal value) of this 43-year-old man equivalent to that of an 85-year-old man. Measurement of total body mineral, spinal mineral, forearm mineral, as well as repeat hip mineral showed all to be markedly depressed. Dual photon absorptometry (DPA) scan indicated his bone mass was 70% of the normal values for his age. Bone biopsy obtained at surgery revealed "no significant histopathological abnormality". Other laboratory studies were normal except for an elevated urinary calcium of 384 (normal up to 300). The patient did not have blue sclerae and had normal ophthalmologic examination. Working clinical diagnosis of osteogenesis imperfecta tarda was entertained.

The patient returned to work three months postoperatively, working as an operation manager for a moving company. He has continued to work full-time. One year postoperatively, he had mild residual lower back ache. His only functional limitation was the inability to run or to get up from a squatting position. Manual motor testing demonstrated normal strength in all major muscle groups of the lower extremi-

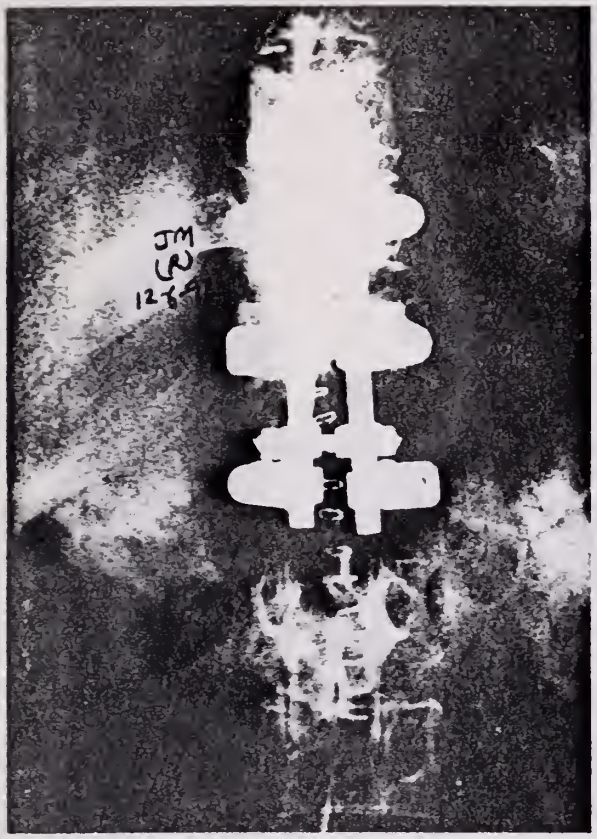

FIGURE 4
Postoperative anteroposterior x-ray of the thoracolumbar vertebrae shows the internal fixation device (Isola system) and satisfactory alignment of the spinal column.

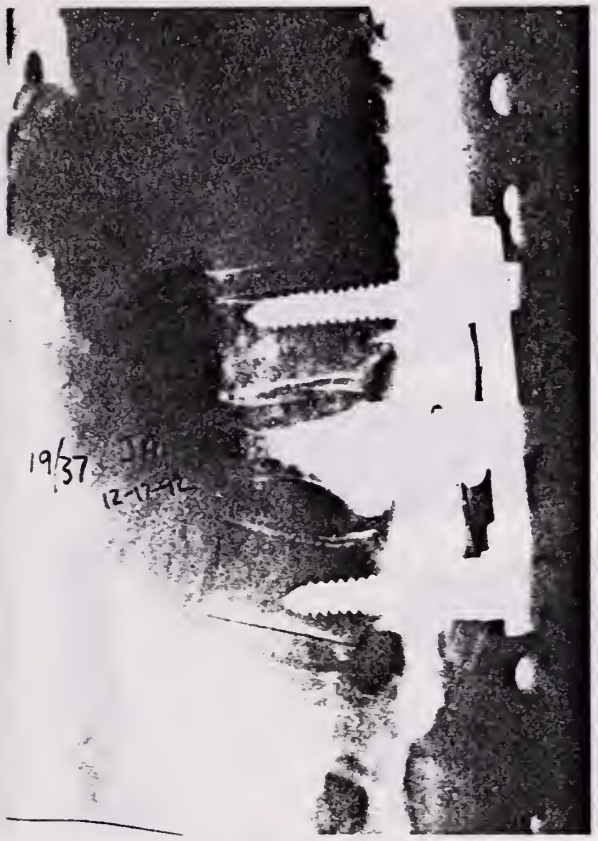

FIGURE 5
Postoperative lateral x-ray of the thoracolumbar vertebrae shows 22° of dyphosis at the fractured vertebra. Anterior and posterior body height were 19 mm and 37 mm respectively.

ties. Sensory examination showed decreased sharp-dull sensation in the plantar surface of his left foot. X-rays one year later showed the fusion to be radiologically healed with 30% residual kyphosis in the fractured vertebra(Figures 6 & 7).

DISCUSSION

The thoracolumbar (TL) region (T11-L2) is a transition zone between the kyphotic, relatively immobile thoracic vertebrae and the lordotic, mobile, lumbar vertebrae making it more susceptible to axial loading injuries. It is also a neurological transitional zone. The spinal cord usually ends here at L1. Good reviews of TL injuries have been presented recently.[3,4] Holdsworth[5,6] classified the spinal injuries into anterior and posterior column injuries. Dennis[7,8] expanded this into the "three column concept". Ferguson and Allen[9] added a mechanical aspect to these concepts: compressive flexion, distractive flexion, lateral flexion, transitional torsional flexion, vertical compression, and distractive extension. Our patient had all three columns disrupted through soft tissue/ligamentous injuries and bilateral facet dislocation with complete spinal instability.

Spinal burst fractures are commonly associated with major trauma with axial loading (i.e., motor vehicle accident, fall from height, etc.). Burst fracture of the spine with minimal trauma in a young patient should arouse the suspicion of a pathological fracture. The radiological evidence of vertebral osteopenia in a young man is a rare finding.[10] It is usually secondary to inherited bone disorders such as osteogenesis imperfecta, or acquired conditions like renal osteodystrophy, osteomalacia, excess inherent or exogenous steroid.[11] Rao et al recently described a 22-year-old patient with two noncontiguous burst fractures of the spine with a minor injury associated with osteogenesis imperfecta.[12] Others have also noted spinal injuries with minimal trauma in osteogenesis imperfecta.[10,11,13,14,15,16]

Treatment options[17] for vertebral injuries include nonoperative management or surgical treatment. Indications for conservative/

FIGURE 6
One year postoperative anteroposterior x-ray of the thoracolumbar vertebrae shows the fusion mass healted solidly and no change in the alignment of the spinal column.

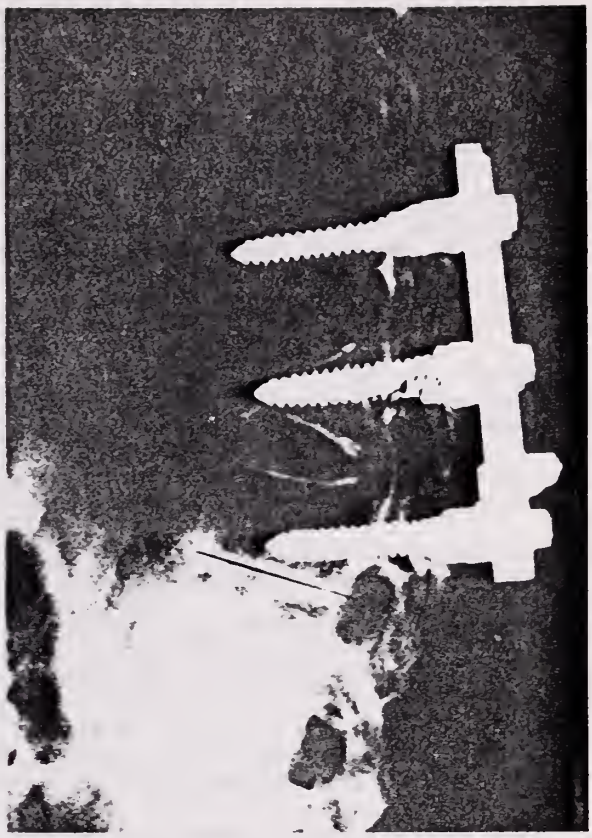

FIGURE 7
One year postoperative lateral x-ray of the thoracolumbar vertebrae shows 30° of kyphosis at the fractured vertebra. Anterior and posterior body height were 20 mm and 35 mm respectively.

nonoperative treatment are well described[18,19,20] and include (1) stable injury with no or minimal bony displacement, (2) no neurological deficit, (3) poor surgical candidate, and (4) associated medical conditions (i.e., recent myocardial infarction, or severe coagulopathy). Nonoperative treatment consists of 1-2 weeks of bed rest for pain control and soft tissue healing followed by ambulation in a hyperextension thoracolumbar orthosis or cast for 3-6 months or more until fracture union. Indications for surgery include (1) displaced fracture with spinal instability, (2) complete or incomplete neurological deficit, (3) >50% loss of vertebral body height, (4) >20° of kyphosis, (5) >30% spinal canal compromise with or without neurological deficit, and (6) multiple trauma.[19,21,22,23] Early surgical intervention is recommended within 48-72 hours of injury.[25] Delayed surgery may produce less desirable results because of limited reduction, possibly due to early fracture healing. Surgical options include an anterior or posterior decompression and fusion, or a combined anterior and posterior approach. Decompression by laminectomy alone is never indicated as it can add to instability and may actually increase early and/or late neurological deficit.[25] Gertzbein et at[26] found no statistically significant difference in the neurological recovery comparing anterior and posterior surgery. Pedicle screw and plate/rod/hook fixation has gained popularity recently.[25,27,28,29] Recent reports confirmed short-term and long-term functional improvement when treated operatively.[15,30] Early aggressive surgical management has been shown to decrease the hospital stay, medical costs, and rehabilitation time.[24,31,32]

CONCLUSION

Significant vertebral column fracture with minimal trauma in relatively young patients should raise the index of suspicion for metabolic or pathological bone disease and the appropriate work up should be carried out.

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ORIGINAL ARTICLE

Breast Cancer Screening: Recent Trends In The Use Of Mammography In Nebraska

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INTRODUCTION

BETWEEN 1988 and 1992, 1,453 Nebraska women died from breast cancer, making it the most frequent cause of cancer deaths among Nebraska women during the period.[1] Since research into the etiology of breast cancer has not yet definitively determined how to prevent new cases from occurring, the widespread application of mammography for screening asymptomatic women remains the best method with which to reduce breast cancer mortality. Although the effectiveness of mammography as a screening tool has been repeatedly questioned, it is important to note that this controversy has focused on the value of mammography for screening women less than 50 years old. For women who are 50-74 years of age, however, the evidence is clear: regular screening by a combination of mammography and physical breast examination will significantly reduce breast cancer mortality.[2] Both the American Cancer Society and the National Cancer Institute recommend that women 50 years of age and over obtain a screening mammogram and clinical breast exam annually.[3]

The purpose of this article is threefold: 1) to report recent trends in the use of mammography among Nebraska women 50 years of age and older, 2) to examine how mammography use differs by certain demographic and socioeconomic factors, and 3) among women who have not had a mammogram within the past year, to determine how long it has been since their last visit to a physician for a routine medical check-up.

METHODS

The data presented here are from the 1988-1992 Nebraska Behavioral Risk Factor Surveys (BRFS). The Nebraska BRFS is a random digit-dial telephone survey of the state's adult population concerning a wide variety of health-related behaviors; the survey is conducted annually and currently interviews about 1,800 people per year. The BRFS was developed and is sponsored by the Centers for Disease Control and Prevention, and is conducted in 47 other states (and the District of Columbia) besides Nebraska. In Nebraska, the BRFS is conducted and supported by the Nebraska Department of Health's Division of Health Promotion/Education.

Women who participated in the 1988-1992 BRFS were asked whether they had ever had a mammogram, and if so, when they had had their last mammogram and whether it was done as part of a routine check-up, because of a breast problem, or because of a previous breast cancer. The same questions were asked regarding clinical breast exams, but only on the 1990-92 BRFS. All 1988-1992 BRFS participants were also asked how long it had been since their last routine check-up by a physician. The wording of these questions, along with the questions pertaining to demographic and socioeconomic factors, was identical in all five surveys.

Analyses were restricted to women 50 years of age and older. The results from individual years were used to analyze trends in the use of mammography. The results from the two most recent surveys (1991-1992) were combined to examine the use of mammography by demographic and socioeconomic factors, and to examine the time since last routine medical check-up among women who had not had a mammogram within the past year.[4] The data were weighted to reflect the age and racial composition of the state according to the 1990 U.S. Census, and also to reflect the probability of selection into the survey sample.

RESULTS

As shown in Figure 1, mammography use among Nebraska women 50 years of age and older increased considerably from 1988 to 1992. The percentage of women who reported that

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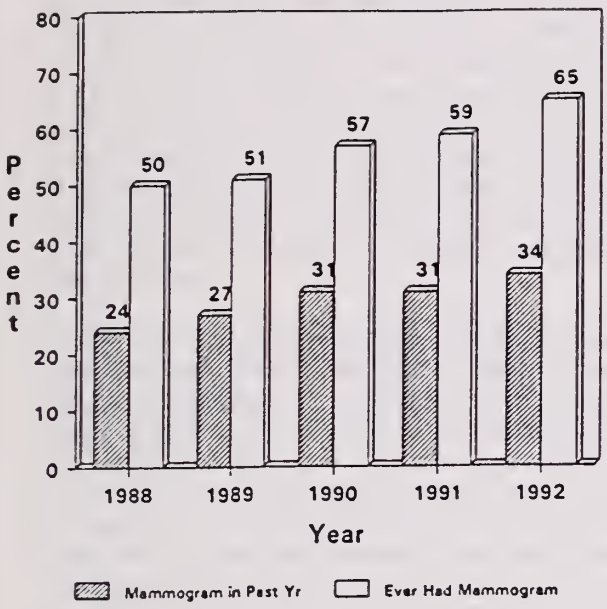
FIGURE 1
Trends in Mammography Use Among Women 50 Years of Age and Older.



Source: Nebraska BRFS, 1988-1992

they had ever had a mammogram increased from 50% in 1988 to 65% in 1992. Similarly, the percentage of women who had a mammogram within the past year also increased, from 24% in 1988 to 34% in 1992. During the same period, the percentage of women who reported that their last mammogram was done as part of a routine check-up increased moderately, from 77% to 85%. In spite of these positive trends, however, Nebraska ranked next to last in 1992 among the 48 states conducting the BRFS in terms of the percentage of women at least 50 years of age who had had a mammogram within the past year.[5]

Table 1 shows that the percentage of Nebraska women 50 years of age and older who have had a mammogram within the past year varies considerably by socioeconomic and demographic factors. Women 65 years of age and older were less likely to have had a mammogram within the past year than women 50-64 years of age, by a margin of 38% to 29%. Women with an annual household income of more than $35,000 were more than twice as likely to have had a mammogram within the past year than women with a household income of less than $15,000 per year (52% vs. 25%). Similarly, women with at least some college education were twice as likely to have had a mammogram within the past year

TABLE 1
Percentage of women >= 50 years of age who reported having had a mammogram within the past year.

	%
All	33
Age	
50-64	38
65+	29
Annual household income	
< $15,000	25
$15,000-$35,000	38
>$35,000	52
Education	
<high school graduate	23
high school graduate	34
>high school	47
County of residence*	
rural	29
urban	40

*Urban defined as residence in Douglas, Lancaster, and Sarpy Counties; rural defined as residence in all other counties.

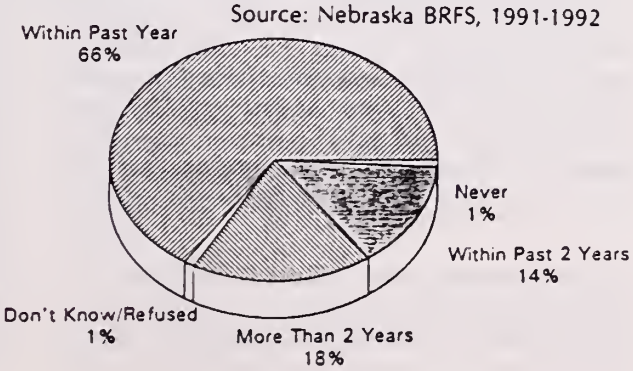
SOURCE: Nebraska BRFS, 1991-1992

than women who had not completed high school (47% vs. 23%). Urban residents (defined as anyone living in either Douglas, Lancaster, or Sarpy Counties) were more likely than rural residents (defined as anyone living outside of Douglas, Lancaster, or Sarpy Counties) to have had a mammogram within the past year, by a margin of 40% to 29%.

For Nebraska women 50 years of age and older who have not had a mammogram within the past year, Figure 2 shows how long it has been since their last visit to a physician for a routine medical check-up. Surprisingly, nearly two-thirds (66%) of the women who reported that they had not had a mammogram within the past year reported that they had seen a physician within the past year for a routine medical check-up.

FIGURE 2
Time since last routine check-up in women 50 and older who did not have mammogram within the past year.

Source: Nebraska BRFS, 1991-1992



CONCLUSIONS

Data from the state's BRFS indicate that the use of mammography for breast cancer screening among Nebraska women age 50 and older increased substantially from 1988 to 1992. In spite of this increase, however, Nebraska continues to have one of the lowest rates of mammography use in the nation. In 1992, only about one-third of Nebraska women 50 years of age and older had had a mammogram within the past year, and even fewer (29%) had had both a mammogram and a clinical breast exam within the past year.

The Nebraska BRFS data also show that women who are age 65 and older are less likely to have had a mammogram within the past year, and this finding has been confirmed at the national level as well.[5] The low rate of mammography use among women who are at least 65 years of age is especially troubling, considering that breast cancer incidence and mortality rates are highest among women in this age group. In fact, the most recent data from the state cancer registry show that over half of all new cases and two-thirds of all deaths attributable to breast cancer in Nebraska occurred among women 65 years of age and older.[6] Moreover, screening mammography seems to be more effective among women 65 years of age and older. A study in progress of over 60,000 women screened with mammography has revealed that mammography has a higher predictive positive value (x 2.0), a higher biopsy yield (x 1.6), and a higher cancer detection rate (x 2.0) in women 65 years of age and older in comparison with women under the age of 65.[7]

Similarly, state and national data confirm the relationship between income and mammography use.[5] The low rate of mammography use among women with the least income was one of the problems addressed as part of the Breast and Cervical Cancer Mortality Prevention Act of 1990, which was passed by the U.S. Congress and signed into law by President Bush in 1991.[8] In conjunction with the federal Centers for Disease Control and Prevention, this legislation led to the creation within the Nebraska Department of Health of the "Every Woman Matters" Program. In addition to publicizing the benefits of and guidelines for breast and cervical cancer screening among all women and health professionals throughout the state, the "Every Woman Matters" Program has developed a statewide network of physicians, mammography facilities, and pathology laboratories who provide mammograms, clinical breast exams, and Pap smears to women who would not otherwise have the means to obtain them. Eligibility for the program is based on annual household income and household size; eligible women receive screening services without cost or for a $5 annual fee. Providers are compensated for their services by the Nebraska Department of Health according to prearranged reimbursement rates. Since its inception in mid-1992, the program has enrolled over 3,000 women, and eventually intends to screen about 10,000 women per year.

The degree to which screening mammograms can effectively reduce breast cancer mortality will continue to rely primarily on their acceptance and active recommendation by physicians. Although the findings from a recent physician survey indicated an increase in their acceptance of mammography screening guidelines and an increase in the percentage who refer their patients for screening mammograms, these same data have also found that many physicians cited the cost, concerns regarding efficacy, fear of radiation, and lack of availability of mammography as factors which deter them from adhering to screening guidelines.[9] Other barriers such as time constraints or lack of an effective office reminder system may also account for poor adherence to screening guidelines. In addition, physician referral may not provide sufficient motivation to some women, although surveys of women themselves have documented that lack of a physician's recommendation is one the most prominent reasons why they do not get them.[10,11] The data presented in this article also suggest that lack of access to health care is not a key factor in explaining the low rates of mammography use in Nebraska, since most women who had not had a mammogram within the past year reported that they had had a routine checkup by a physician within the past year. In fact, referrals for screening mammograms for women who are already in the care of a physician probably represent the best opportunity for improving Nebraska's low rate of compliance with current screening guidelines. Among women 50 years of age and older, the percentage of women who reported in 1992 that they had had a mammogram within the past year would have increased from 34% to 77% had all of those who had seen a physician for a routine medical check-up within the past year been screened.

Finally, if the benefits of early treatment are to be assured for women with a screening-detected cancer, physicians and health-care organizations must ensure timely patient management. Breast

cancer can display widely-varying growth rates and aggressiveness, and any delay in establishing a diagnosis or instituting appropriate treatment may have deleterious consequences for an individual patient. Using the traditional communication methods of written report and direct telephone contact, a Massachusetts General Hospital study revealed 16% incomplete evaluation at 3.5 months and 6% at 4.5 months after initial screening mammogram.[12] Similarly, a University of California-San Francisco (UCSF) study found 11.1% of patients with abnormal screening mammograms lost to follow-up after six months.[13] However, using a computerized patient database management system which generated reminder letters, a subsequent UCSF study found less than 1% with abnormal screening mammograms lost to follow-up after six months.[13] Given these findings, screening facilities in Nebraska should consider conducting their own follow-up studies and also consider implementation of a computerized patient management system.

SUMMARY

Although the efficacy of screening mammography has been surrounded in controversy of late, the evidence that it can reduce breast cancer mortality among women 50-74 years of age is extremely sound. In Nebraska, data from the state's Behavioral Risk Factor Survey show, that during the years 1988 to 1992, the percentage of women age 50 years and older who had ever had a mammogram rose from 50% to 65%, while the percentage of women of the same age who had had a mammogram within the past year rose from 24% to 34%. Nebraska BRFS data also show that the percentage of women 50 years of age and older who have had a mammogram within the past year varies considerably by age, income, education, and county of residence. Among women who have not had a mammogram within the past year, 66% reported that they had seen a physician within the past year for a routine check-up. Prompt and appropriate follow-up of abnormal findings by both physicians and health-care organizations is also essential to ensure the maximum benefit of screening mammography.

ACKNOWLEDGMENTS

This research was supported by Cooperative Agreement #U57/CCU706734-02 between the Centers for Disease Control and Prevention and the Nebraska Department of Health. The authors also wish to thank Sue Huffman, Coordinator of the Nebraska BRFS, for her helpful comments and suggestions in the preparation of this manuscript.

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COMMENT

As a radiologist in a group that reads thousands of mammograms a year, I oftentimes tongue in cheek ask myself (usually at 5 o'clock on Friday afternoon) how there could possibly be any more women who need a mammogram. The truth of the matter is that there are literally thousands of women in Nebraska who should be undergoing mammography, regardless of whose recommendations one follows. The data presented by Rettig et. al. has been a source of mystery and concern since its initial collection in the late 1980's. Nebraska has always been in the bottom third in mammograms and it was rumored that this aided in the award of the CDC grant and creation of the "Every Women Matters" Program.

And now Nebraska is next to last in terms of women over 50 who had a mammogram within the past year. My heartfelt concern is that some of these women may have been symptomatic or in a high risk group. This survey grouped all reasons for mammography, and from our personal hospital mammography QA, I know that some women with the diagnosis of breast cancer have never had a mammogram. Even if a palpable mass is present there may be a synchronous nonpalpable or a contralateral breast cancer present.

The reasons for Nebraska's low rate is perplexing and undoubtedly due to a myraid of reasons. The District of Columbia had the highest rate of women getting mammograms in the past year (60.2%) but I doubt crime and the number of politicians had any bearing. All of our neighboring states were between 41-51% yearly followup after age 50, with South Dakota at 41% and Colorado at 51%. Seven states ranked with Nebraska below 40%.

I find that many care providers lack a practical algorithm for breast problems. And many are uncertain of any screening guidelines. First of all I would find a set of guidelines that your professional society has endorsed, or that you have researched, and use them for screening purposes in women who have a negative breast exam. I espouse the screening recommendations put forth by the American Cancer Society and American College of Radiology. A baseline mammogram between ages 35-40, biennial screening between 40-50, and annual screening after age 50. This will raise the ire of many who feel that screening should not begin until age 50, but I feel we are still in the data collecting stage of a humbling cancer and the technical improvements of mammography equipment improve yearly thereby allowing better quality, less radiation and potentially an earlier diagnosis of some cancer types. It is not unethical nor malpractice to perform mammography before age 50.

Once you have decided upon a screening protocol, then predetermine what you will do for women in the 20-30, 30-40, and over 50 year age groups who come to you with a breast problem. Consulting with your area surgeon or radiologist is recommended. Again mammography, coupled with ultrasound and biopsy (which can be either open, stereotactic, or by ultrasound) will assist you in solving the problem. It will also aid you in any litigation that comes down the dusty road in later years. And yes, mammography is useful in women with implants, and no, they will not rupture during breast compression.

The good news is that when you are so low in the ratings you can only go one way. Nebraska physicians will certainly rise to the challenge of improving our mammography rates where appropriate. By the way, who was last? Mississippi.

Joe Stavas, M.D.

PERINATAL PAGE

The Pregnant Patient Experiencing Trauma

MICHAEL G. LEVINE, M.D., FACOG
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Methodist Perinatal Center
Omaha, Nebraska

THE pregnant woman is more predisposed to trauma because of an assortment of physiologic changes due to pregnancy. She more easily becomes fatigued, and can experience a greater frequency of hypoglycemia, postural hypotension, and fainting episodes. Postural changes can lead to unsteadiness and impair neuromuscular control.

The exact incidence of physical trauma during pregnancy, ranging from minor to catastrophic, varies significantly among populations studied. Various authors estimate that 6-7% of all pregnancies, or approximately 1 in 12, suffer physical trauma.[1]

In order to adequately evaluate and treat a pregnant trauma patient, the clinician must be familiar with the normal physiologic changes of pregnancy.

Maternal cardiac output increases by 40% during the gestation. Supine positioning during the second half of the gestation causes significant aorto-caval compression with decreased venous return. cardiac output, and uterine perfusion. At the start of the third trimester, maternal blood volume has expanded by 45% and is maintained at that level for the remainder of the pregnancy. The resting maternal heart rate increases 15-20 BPM in the third trimester. The systolic and diastolic blood pressure decrease by 15 mmHg in the second trimester, returning to pre-pregnant levels by term. The increase in plasma volume produces a physiologic anemia of pregnancy. Coagulation factor levels rise during pregnancy, with associated increased risk of thrombosis and pulmonary embolus. Maternal tidal volume and respiratory rates are increased with a relative respiratory alkalosis. Due to a shift in the position of the stomach, reflux with aspiration of gastric contents is of concern. The intra-abdominal organs are displaced cephalad by the pregnant uterus. The urinary bladder is displaced upward becoming an abdominal organ by the 12th week of gestation, and is more prone to injury. The renal pelvis and ureters undergo physiologic hydronephrosis during the first trimester, until six weeks post delivery. The uterus undergoes a dramatic increase in size by term. The enlarging uterus becomes more at risk to trauma. Blood flow to the uterus increases 10 fold by term, predisposing a pregnant woman to significant blood loss if the uterine vessels are disrupted.[2]

Categories of Trauma:

The leading cause of more serious maternal injuries during pregnancy is motor vehicle accidents. Other causes of blunt abdominal trauma include accidental falls, and direct blows to the abdomen.

The enlarged uterus with its increased blood flow predisposes the pregnant woman to Intra-abdominal injuries following blunt trauma. Splenic rupture and retroperitoneal hemorrhage are common complications, however, bowel injuries occur less often. Uterine rupture occurs infrequently, complicating .6% of traumatic injuries. However, it can be life threatening to both mother and fetus, since it is associated with hemorrhagic shock in the most severe trauma cases. Fetal injuries can also occur secondary to blunt maternal abdominal trauma. The fetal skull and brain are most often injured after direct trauma to the abdomen. These injuries occur due to concomitant maternal pelvic fractures, and the excessive acceleratory and deceleratory forces involved. The most common cause of fetal death following severe trauma is maternal death.[3,4,5,6]

Abruptio placenta occurs in 40-50% of severe maternal injuries as well as 1-5% of minor trauma. Placental separation occurs due to the stretching of the myometrium around the relatively inelastic placenta, causing the placenta to separate from the underlying decidua. The significant simultaneous increase in intra-amniotic pressure further causes the placenta to shear away from the decidua. With disruption of the utero-placental unit, the fetus is at risk for hypoxia, acidosis, or death.[7]

Penetrating injuries to the maternal abdomen are less frequent than blunt trauma. Gunshot and

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stab wounds make up the majority of these injuries. Maternal mortality tends to be lower than in the non-pregnant patient since the uterus acts as a shield for abdominal organs during penetrating injuries. Maternal injury to abdominal organs other than the uterus has been reported at 19% following gunshot wounds to the abdomen in pregnancy. However, injury to the fetus was 59-80% with a perinatal mortality of 41-71%.[8]

After experiencing trauma the first treatment priority is maternal stabilization. It is important to follow the same evaluation and procedures as in a non-pregnant patient. These should include maintaining an airway with adequate oxygenation, and circulatory volume. An infusion of crystalloid in the form of lactated Ringer's solution or normal saline through two large intravenous catheters should be utilized for blood loss and fluid replacement.

Patients in the second half of pregnancy should be in the lateral decubitus position. This will reduce the pressure of the uterus on the abdominal aorta and inferior vena cava which will improve maternal venous return and cardiac output. If the patient must remain supine to immobilize the spine or to initiate cardiopulmonary resuscitation, then a wedge can be inserted under the patient's hip or the uterus manually deflected to the left. Other measures of stabilization can include a nasal gastric tube, Foley catheter, and oximetry readings.

A more detailed history and physical assessment, including fetal status, can be performed following stabilization. Electronic fetal monitoring can be helpful in ruling out abruptio placenta. Abnormalities of the fetal heart rate including tachycardia, absent variability, late decelerations, or the presence of uterine contractions may necessitate early intervention. In the case of minor maternal trauma, fetal monitoring should be continued up to six hours.[9] Ultrasound can provide information pertaining to gestational age, fetal position, placental localization, status of the fetus, and amniotic fluid volume. It is not as helpful to rule out abruptio placenta when compared to electronic monitoring.

The risk of fetal maternal hemorrhage is significantly increased following trauma. The administration of Rh(D) immunoglobulin should be considered with the first 72 hours to protect against (D) isoimmunization. Other considerations should be tentanus immunization and antibiotics.[9,10] Laboratory assessments should be individualized to the specific clinical conditions that are present.

When the clinician is confronted with severe maternal trauma, a perimortem cesarean section should be considered. A cesarean section may improve the resuscitation efforts of the mother, by increasing venous return and cardiac output. The fetus is more likely to survive if the cesarean section is performed within 5 minutes of absent vital signs. However, fetal survival can occur up to 20 minutes following maternal death.[11]

In summary, the clinician must be familiar with the normal physiologic changes of pregnancy, in order to adequately treat maternal trauma. Volume replacement, oxygenation, and left lateral positioning to maintain adequate venous return and cardiac output are priorities towards maternal stabilization. Following maternal stabilization, the fetal status should be assessed utilizing fetal monitoring to rule out fetal jeopardy with ultrasound for fetal size, gestational age, and placental localization. Laboratory examination should be performed to assess fetal maternal hemorrhage and the need for intervention. Perimortem cesarean section may assist in maternal resuscitation and may salvage the fetus if performed expediently following maternal death.

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ASK A LAWYER

1. What does the new Nebraska law require with respect to a physician reporting another physician for licensure disciplinary purposes?

A physician must report to the Department of Health within thirty days if he or she has first-hand knowledge of facts giving him or her reason to believe that another physician has committed acts of gross incompetence, a pattern of negligent conduct, unethical or unprofessional conduct, or practicing while impaired by alcohol, drugs, or physical, mental or emotional disability.

2. What does the new law provide with respect to cross-professional reporting?

Health care professionals included in the new law must report a person of another health profession to the Department of Health within thirty days whenever he or she has first-hand knowledge of facts giving him or her reason to believe that the person has committed acts of gross incompetence or is practicing while inpaired by alcohol, drugs, or physical, mental or emotional disability. The rule for cross-professional reporting does not include a duty to report a pattern of negligent conduct or unethical or unprofessional conduct.

3. What other health care professionals are included in the new law?

The new law includes those practicing in the fields of medicine, surgery, pharmacy, psychology, funeral directing and embalming, dentistry and dental hygiene, podiatry, veterinary medicine, athletic training, respiratory care, chiropractic, optometry, dietetics and nutrition, mental health practice, osteopathic medicine, massage therapy, physical therapy, audiology and speech-language pathology.

4. How many disciplinary petitions are filed by the Nebraska Attorney General against physicians in Nebraska each year?

Thirteen petitions were filed in 1989; seven in 1990; nine in 1991; thirteen in 1992; and nine in 1993.

5. What are the most common types of disciplinary petitions filed in Nebraska against all health care providers, including physicians?

Unprofessional conduct petitions are the most common. The breakdown for the last three years looks like this:

	1991	1992	1993
Unprofessional Conduct	55	35	46
Grossly Immoral and Dishonorable Conduct	15	17	32
Fraudulent Practice	19	17	21
Impairment/Addiction	30	12	12
Beyond Authorized Scope	18	14	21
Incompetence/Negligence	16	1	5
Felony Conviction	4	1	2
Other	77	40	37

6. What are the most common types of actions taken against a physician after a disciplinary petition has been filed?

The most common action taken is probation. Statistics for the last five years are:

	1989	1990	1991	1992	1993
Probation or Limitation of License	3	8	8	3	7
Reprimand	1	1	3	0	2
Revocation of License	1	1	3	1	0
Suspension of License	0	2	1	2	0
Civil Money Penalty	0	0	1	1	1
Surrender of License	1	1	0	0	0

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"Ask a Lawyer" is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the **Nebraska Medical Journal**. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen, with the assistance of UNL College of Law student Jane Evers of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

COMING MEETINGS

CREIGHTON UNIVERSITY

JULY 27, 28, 1994 — Third Annual Conference: Current Concepts in Sub-Acute Care, Defining The Difference, Marriott Hotel, Omaha, NE.

AUGUST 4-8, 1994 — Anesthesiology Review Course - Professional Seminars - Nashville, TN.

AUGUST 31, 1994 — New Management Options in Bipolar Disorder - St. Joseph Center for Mental Health - 10:00 am - 12:00 pm.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

SEPTEMBER 29, 1994 — Ultrasonography - Marriott Hotel - Omaha, NE.

SEPTEMBER 30 - OCTOBER 1, 1994 — Day With the Perinatologists - Marriott Hotel, Omaha, NE.

OCTOBER 4, 1994—T.T. Smith Lecture, BTNRHA.

OCTOBER 7, 1994 — Fifth Annual: Come Home to Creighton, Skutt Student Center, Creighton University, Omaha, NE.

OCTOBER 8, 1994—Cardiology Program - Henry Doorly Zoo

OCTOBER 19, 1994 — Distinguished Lecture Series, William J. Hoskins, M.D.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite 2130, Omaha, NE 68131.

MAYO FOUNDATION

OCTOBER 16, 1994 and OCTOBER 30, 1994 — Problem Solving in Hypertension, Mayo Foundation, Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

OCTOBER 29, 1994 — Update and Case Reviews in Otorhinolaryngology - Head & Neck Surgery, Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

NOVEMBER 3-4, 1994 — Mayo Clinic Ob/Gyn Clinical Review, Mayo Foundation Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

NOVEMBER 12-13, 1994 — Monitoring Neural Function During Surgery, Mayo Foundation Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

APRIL 6-9, 1995 — 2nd Int'l Conference on the Medical Aspects of Telemedicine & 2nd Annual Mayo Telemedicine Symposium, Mayor Clinic, Rochester, MN: Mayo Clinic Jacksonville, FL; Mayo Clinic Scottsdale, AZ. Contact: Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

SEPTEMBER 15-17, 1994 — Fall Session, Cornhusker Hotel, Lincoln.

APRIL 27-30, 1995 — Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

UNIVERSITY OF NEBRASKA MEDICAL CENTER EMERGENCY MEDICAL SERVICES

JULY 21-22, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

AUGUST 22-23, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA Catagory I, 14.5 Prescribed Hours AAFP. Fee: $195.

SEPTEMBER 9-10, 1994, FRIDAY, SATURDAY — Advanced Trauma Life Support (ATLS). Good Samaritan Hospital, Kearney, Nebraska, Target Audience: Physicians, Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.0 Hours ACEP Category I. Fee: $550.

SEPTEMBER 12, 1994, MONDAY — Advanced Cardiac Life Support (ACLS) Renewal, University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.00

SEPTEMBER 13, 1994, TUESDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

SEPTEMBER 13, 1994, TUESDAY — Pediatric Advanced Life Support (PALS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses. Credit: 4 Hours AMA Category I. Fee: $50.

SEPTEMBER 15-16, 1994, THURSDAY-FRIDAY— Trauma Nurse Core Course (TNCC). Regional West Medical Center, Scottsbluff, Nebraska. Target Audience - Nurses. Credit: 18 CECH's of BCEN's Category of Clinical. Fee: $210 - Non-ENA Members, $174 - ENA Members.

SEPTEMBER 22-23, 1994, THURSDAY-FRIDAY— Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.0 Hours ACEP Category I. Fee: $550.

SEPTEMBER 24, 1994, SATURDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee $110.

SEPTEMBER 24, 1994, SATURDAY — Advanced Trauma Life Support (ATLS) Reverification, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 3 Hours AMA Category I, 3 Prescribed Hours AAFP, 3 Hours ACEP CAtegory I. Fee: $185.

OCTOBER 3-4, 1994, MONDAY-TUESDAY — Advanced Live Support in Obstetrics (ALSO). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Family Physicians, Obstetricians, General Practitioners, Emergency Physicians, Surgeons, Nurse Midwives, Obstetrical Nurses. Credit: 14 Hours AMA Category I, 16.0 Prescribed Hours AAFP. Fee: $300 - Physicians, $225 - Nurses.

OCTOBER 10-11, 1994, MONDAY-TUESDAY— Pediatric Advanced Life Support (PALS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses. Credit: 13 Hours AMA Category I. Fee: $175.

OCTOBER 20-21, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA CAtegory I, 14.5 Hours Prescribed Hours AAFP. Fee: $195.

OCTOBER 24-25, 1994, MONDAY-TUESDAY— Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.9 Hours ACEP Category I. Fee: $550.

OCTOBER 31 - NOVEMBER 1, 1994, MONDAY-TUESDAY — Trauma Nurse Core Course (TNCC), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience - Nurses. Credit: 18 CECH's of BCEN's Category of Clinical. Fee: $210 - Non-ENA Members, $175 - ENA Members.

NOVEMBER 7-8, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Profes-

sionals. Credit: 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

DECEMBER 1, 1994, THURSDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.

DECEMBER 2, 1994, FRIDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

DECEMBER 2, 1994, FRIDAY — Pediatric Advanced Life Support (PALS) Instructor, University of Nebraska Medical Center Campus, Omaha, Nebraska. Credit: 4 Hours AMA Category I, 4 Hours Prescribed Hours AAFP. Fee $50.

For further information: Contact Cindy Hanssen, University of Nebraska Medical Center, Center for Continuing Education, 600 So 42nd Street, Omaha, Nebraska 68198-5651. Call (402) 559-5919 or use our toll free MD ADVANTAGE NUMBER AND ASK FOR CONTINUING EDUCATION (1-(800)652-1095 NATIONWIDE. FAX NUMBER (402) 559-5915.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

JULY 19-22, TUESDAY-FRIDAY — Pan Pacific Lymphoma Conference, The Ritz Carlton - Mauna Lani, Kohala Coast, Hawaii. Target Audience: Physicians and researchers interested in the field of Oncology/Hematology. Fee: $395 before 6/1/94, $450 after 6/1/94.

JULY 29, 1994, FRIDAY — Eating Disorders, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Primary Care Physicians, Psychologists, Nurses, Dietitians, Social Workers, and anyone who cares for patients with eating disorders. Fee: $30.

AUGUST 19-21, 1994, FRIDAY-SUNDAY — Midwest Breast Imaging Conference, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians, Technologists. Fee: $250 before 7/1/94. $300 after 7/1/94 ($150/$200 for Technologists).

SEPTEMBER 17, 1994, SATURDAY — 7th Annual Internal Medicine Update, University of Nebraska Student Union, Lincoln, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER, Fee: $45.

SEPTEMBER 26, MONDAY, — OCTOBER 1, 1994, SATURDAY — Emergency Medicine, 1994, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

OCTOBER 7, 1994, FRIDAY AFTERNOON — University of Nebraska College of Medicine Alumni Day (in conjunction with the Omaha Midwest Clinical Society Meeting), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: College of Medicine Alumni.

OCTOBER 8-12, 1994, SATURDAY - WEDNESDAY — North American Society of Pediatric Gastoenterology and Nutrition, Westin Galleria Hotel, Houston, Texas. Target Audience: Physicians and scientists interested in the field of pediatric gastoenterology and nutrition.

OCTOBER 14-17, 1994, FRIDAY EVENING-MONDAY — Advanced Curriculum on Women's Health - Part II, Adam's Mark, Philadelphia, Pennsylvania, Target Audience: Primary Care Physicians.

OCTOBER 19, 1994, WEDNESDAY — Advanced in Acid Related Diseases, Omaha Marriott, Omaha, Nebraska. Target Audience: Primary Care Physicians.

OCTOBER 22, 1994 — Transfusion Medicine, University of Nebraska Medical Center. Target Audience: Surgeons and Anesthesiologists.

NOVEMBER 12, 1994, SATURDAY — Evaluation and Management of the Swollen Extremity, UNMC, College of Nursing, Omaha, Nebraska. Target Audience: Primary Care Physicians and Nurses.

DECEMBER 1-3, 1994, THURSDAY-SATURDAY — Obstetrics and Gynecology Conference, Bally's, Las Vegas, Nevada. Target Audience: Primary Care Physicians, Obstetricians and Gynecologists. Fee: $275.

MARCH 5-10, 1995, SUNDAY-FRIDAY — 15th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MARCH 27-APRIL 7, 1995, 11 DAYS — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

APRIL 24-MAY 5, 1995, 11 DAYS — Family Practice Review , Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

JUNE 2-3, 1995, MONDAY-TUESDAY— Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

JUNE 9-10, 1995, FRIDAY-SATURDAY — 3rd Annual Diagnostic Dilemmas in Women's Health Care, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Physician Assistants. Fee: $200.

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AMA NEWS NOTES

VACCINES FOR CHILDREN PROGRAM UNDER WAY

The AMA Division of Health Science will coordinate a multispecialty program to inform physicians about the new federal Vaccines for Children program.

Participating organizations include the American Academy of Pediatrics, American Academy of Family Physicians, and American Osteopathic Association.

The AMA and other medical associations are working to clarify physicians' fees for administering the vaccine.

The federal government will make $400 million available this year to buy vaccines for children up to 18 years old.

Vaccines will be provided to private physicians enrolling in the program; enrollment begins Oct. 1.

* * *

AMA CHALLENGES RJ REYNOLDS' CLAIM ON PASSIVE SMOKE

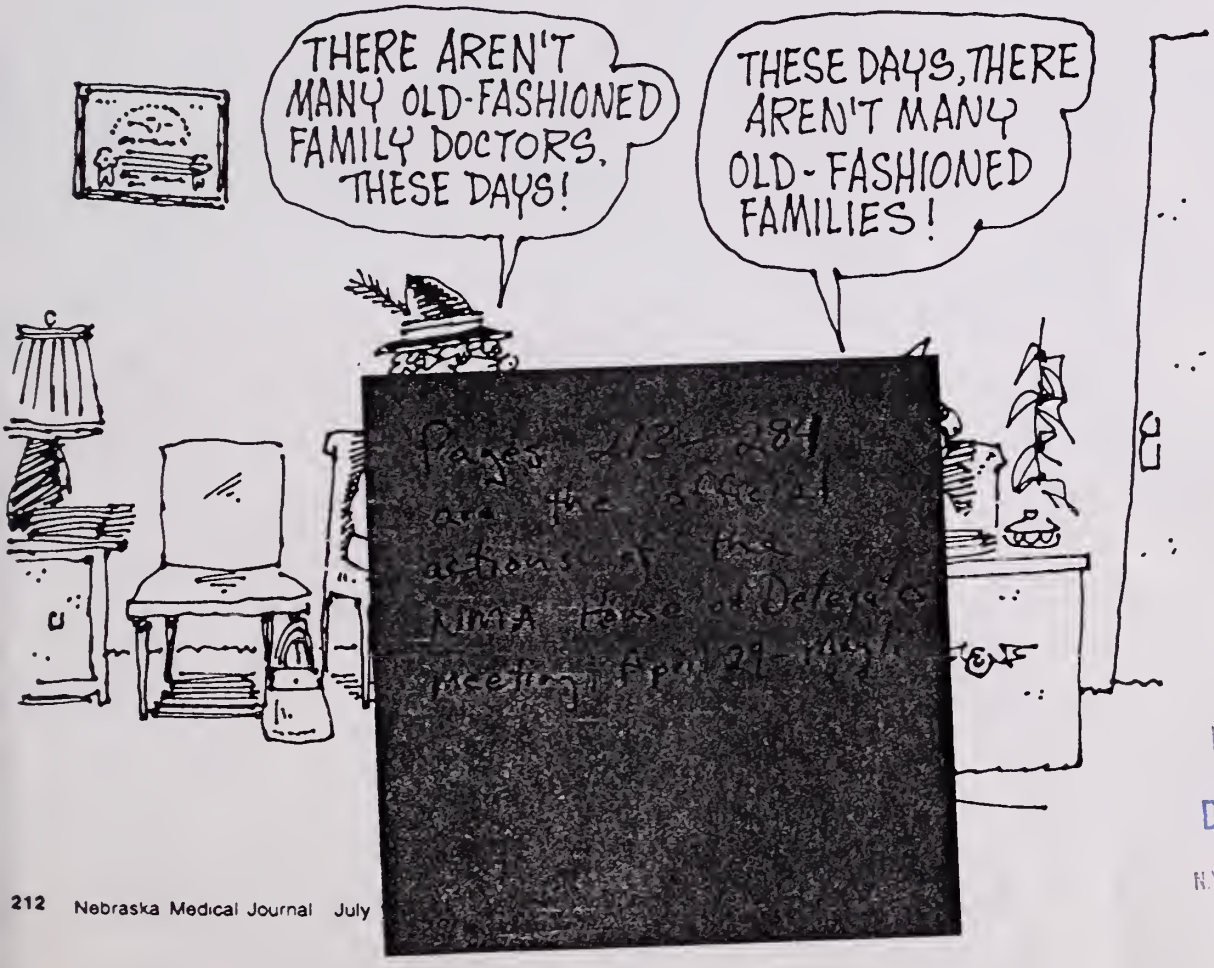
The AMA refuted RJ Reynolds' ad campaign denying the dangers of passive smoke.

"It is not surprising that RJ Reynolds would deny that passive smoke is dangerous," said AMA Board Chair Lonnie R. Bristow, M.D. "If you can smell, taste, and see smoke, you are, indeed, breathing it in and may be suffering for it."

Second-hand smoke is the leading cause of indoor air pollution, Dr. Bristow said, and the third leading preventable cause of death after direct smoking and alcohol.

"RJR's attempt to bury the truth about passive smoke exposes the company's true mission - profit over public health," Dr. Bristow said.

"RJR needs to talk to the husbands, wives, and children of smokers, who themselves have lung cancer, asthma or any of a number of other diseases caused by passive smoke. These people would let RJR know how it really is."



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Nebraska Medical Journal

A NEW ERA OF EXCELLENCE IN CANCER CARE

Treating Cancer Takes Teamwork

Today, leading cancer experts are combining sophisticated treatment modalities — surgery, chemotherapy and radiation therapy — with increasingly better results. This type of care requires new levels of collaboration between surgeons, medical oncologists, radiation oncologists, radiologists, pathologists and other health care professionals.

The Methodist Cancer Center was designed from the ground up to foster an interdisciplinary approach to cancer care. ***In this special setting, up to two dozen doctors contribute their expertise and understanding of cancer care. They confer weekly to develop comprehensive treatment plans for people who have been diagnosed with cancer.***

Interdisciplinary care teams, composed of specialty physicians, oncology nurses, pharmacists, therapists, dietitians, counselors, social workers and chaplains and guided by a medical oncologist, provide care at the Methodist Cancer Center. They coordinate services to meet the patient's home health care needs and meet regularly to assess patient progress. The patient's primary physician receives regular updates and participates in follow-up care.

For more information on the services available through the Methodist Cancer Center or to refer a patient, call the Physicians' Priority Line, 1-800-627-6363.

"The Methodist Cancer Center will enhance patient care by integrating multiple cancer treatment specialists and services in a single location."

David Silverberg, MD,
medical oncologist

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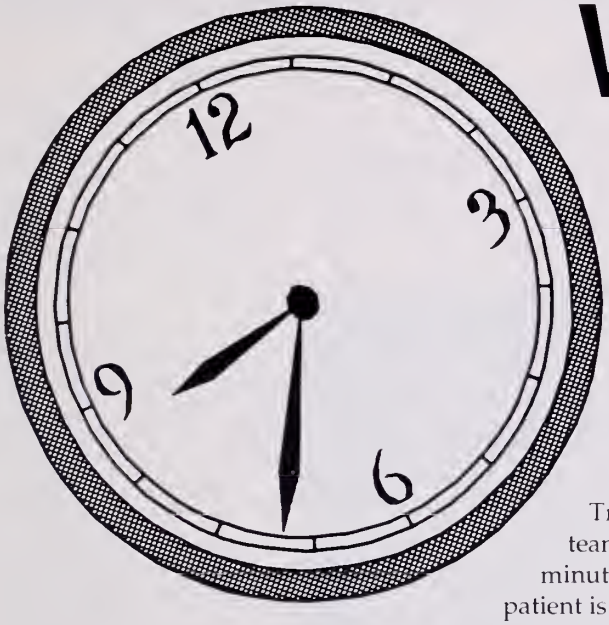

When seconds count ...

For trauma patients, seconds count.

At Lincoln General's Trauma Center, our trauma team is ready for action the minute we're notified that a patient is in route.

Our nurse trauma coordinator keeps you, the primary physician, as well as the transferring hospital informed of your patient's progress through a follow-up phone call.

And once a patient stabilizes at the Trauma Center, other physician specialists are called in. For catastrophic injuries, Madonna Rehabilitation Hospital gets involved right away.

Madonna's rehabilitation experts know that early assessment makes a big difference. We evaluate patients for rehabilitation while they're still at Lincoln General. And as the primary physician, you are an active member of the rehabilitation team.

Seconds count in health care, and so do years. With over 30 years of experience in rehabilitation, Madonna helps patients regain their independence and return to their families, their jobs, their communities. For 12 years, Lincoln General has focused on trauma care as the only Trauma Center in Nebraska verified by the American College of Surgeons Committee on Trauma.

Responsive. Informative. Accessible. The professionals at Lincoln General Hospital and Madonna Rehabilitation Hospital are just a toll-free phone call away, any time of the day or night. When seconds count, count on us.

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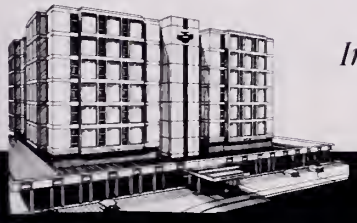
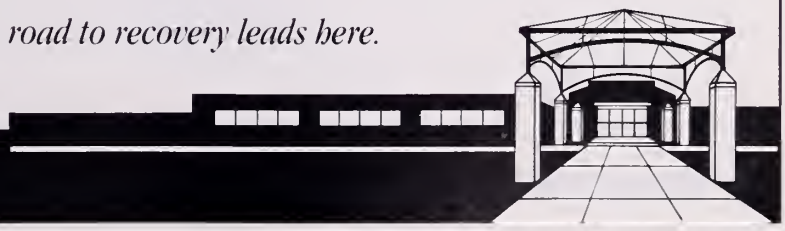


In Nebraska, the road to recovery leads here.



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Storz Cancer Institute's Support Team works closely with each physician in planning and providing care. The team brings together individuals specialized in all aspects of cancer care. Team members or services include a nurse coordinator, oncology nurse, radiation oncology nurse, radiation therapist, medical social worker, chaplain, nutrition care specialist, home care providers, dismissal planning, rehabilitation/physical therapy, occupational therapy, speech therapy and support sessions.

For more information, call the Storz Cancer Institute at 402-552-6932 or call MD Source toll-free at 1-800-552-5552.

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Adults who require more intervention than seeing a mental health professional weekly, but less than around-the-clock inpatient hospitalization, have another option in Lincoln — partial hospitalization services.

The adult program is offered by Lincoln General Hospital's Mental Health Services in addition to the Child & Adolescent Psychiatric Services partial hospitalization program which has been available for years. These partial hospitalization programs are an integral part of the range of Mental Health Services provided by Lincoln General.

Partial hospitalization is a short-term, active treatment program which provides therapeutic, coordinated, and structured clinical services in an open, stable environment. The program is designed to serve individuals with significant impairment resulting from a psychiatric, emotional or behavioral disorder. Since the program is housed at Lincoln General, immediate access to acute care medical services is available when needed.

Partial hospitalization allows Lincoln General to provide a full continuum of comprehensive Mental Health Services, from inpatient care to support groups. For more information, please call **473-5987.**

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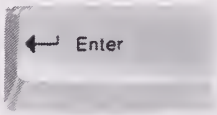

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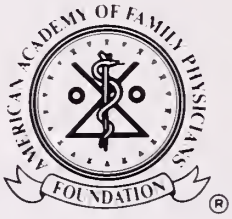

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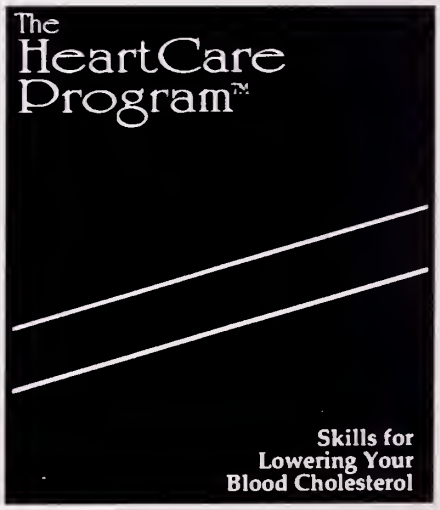

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PRESIDENT'S PAGE

The AMA Patient Protection Act and A Tribute to Jerald R. Schenken, MD

FREDERICK F. PAUSTIAN, M.D.

The American Medical Association Patient Protection Act was introduced to the Senate of the United States on May 23, 1994, S2196, and subsequently to the House of Representatives, HR 4527. As a consequence of its strong patient advocacy emphasis, it has developed considerable interest and support in both houses. Important provisions have been adopted by both the Senate Labor and Human Resources Committee and by the House Ways and Means Committee. The act does not maintain the status quo as our future health delivery system. It does provide for multiple options permitting each individual to select a health insurance plan which is most appropriate for his or her circumstances.

The act is strongly protective of consumer choice through provisions which provide for choice of health plan, choice of physician within a plan and choice of medical treatment. It must be understood by both patients and physicians that these choices are not without constraints and that in order to exercise the proper choice, an in-depth understanding of the available medical service plans is essential.

Much to the dismay of many physicians, the act is not a "willing provider" bill. Provisions of the proposed legislation give physicians the opportunity to apply for participation in a specific health plan but there is no guarantee or requirement that the application must be approved. Managed care plans may establish selection criteria and limit the number and specialty mix of physicians based on need. Physician selection criteria are to be based on professional qualifications and, where documented, prior quality of care performance. There must be in place, however, a mechanism for health care providers to appeal a plan's decision to terminate a physician's participation for cause, thereby requiring the provision of due process. Were insurance companies able to terminate physicians without cause they would have tremendous leverage to withhold appropriate medical services and thereby put the plans financial bottom line ahead of patient health needs.

Frederick F. Paustian, M.D.

A very important provision of the act concerning managed care plans, permits enrollees to seek and obtain out of network medical treatment and services provided the policy holder has purchased a so called "point of service " option for medically necessary and appropriate treatment. Such an option requires cost sharing at a reasonable rate on the part of the enrollee so as to assure the provision is not abused. The point of service option truly allows for patient control over medical care.

A major provision of the Patient Protection Act requires the Secretary of HHS to establish quality standards and a process for certification of managed care plans and utilization review programs together with periodic reviews for recertification or decertification. Managed care plans will be required to provide clear and accurate information as to the medical benefits of the plan as well as coverage exclusions. Incentives that reward hospitals and physicians for delivering less care must be specified. The liability for co-pays, coinsurance, and other payments must be clearly indicated and there must be full disclosure by the plan as to how the premium dollar is expended. Of great importance for both patients and physicians is the

provision for participating physicians to have input into the establishment of the plan's medical care policies and their application regarding coverage and utilization review criteria.

The standards for utilization review programs require that the screening criteria must be publicly disclosed, scientifically valid, and developed in cooperation with physicians and other health providers. Only a physician in the same discipline of medicine may recommend denial of coverage for a service recommended by a treating physician. In addition the reviewing physician must be licensed to practice medicine in the state where the medical service is provided. So as to expedite medical care, prior authorization requests must be answered within two business days and in the event of medical necessity, answered by telephone within twenty-four hours. Prior authorization for true emergency medical service is not required.

In view of the long-standing tradition of Nebraska physicians being patient advocates, it is very important that we now provide strong support for the AMA Patient Protection Act. Direct communication with our congressional delegates is required if the provisions of the Patient Protection Act are to be enacted. When communicating with our Senators and Representatives in the House, the following points must be specified:

1. Patients and physicians must control the care patients receive - not insurance companies.
2. Patients must have a choice of physicians and health plans - HMO, PPO, and traditional indemnity health insurance.
3. Patients must receive information about the benefits and exclusions of the plan, copayments, and prior approval requirements.
4. No physician can be separated from the plan for providing patients with the care they need.
5. Patients who choose a plan that restricts access to physicians must be allowed to purchase a point of service option to see a physician outside of the plan.
6. Physicians must be empowered with a strong position to speak in behalf of their patients and to make medical policy.
7. Practicing physicians must have an essential role in developing criteria and other measures to insure quality patient care.
8. Managed care plans must disclose to physicians the medical personnel who are reviewing their work and, if requested, disclose the reviewers names and credentials.

For more detailed information on the Patient Protection Act, recommended reading includes the AMA publication, Advocacy Initiative - To Enhance Patient Choice in Health Care, June 1994.

A Tribute to Jerald R. Schenken, M.D.

While health system reform is dominant in the thinking of our practicing physicians today, we must not forget the effort, dedication, commitment, and resultant contributions that Jerald R. Schenken, M.D. made to organized medicine in behalf of all physicians. This brief tribute to Dr. Schenken is highly warranted for the work he has accomplished in the many facets of his professional and political life including academic activities, specialty society activities, political activities, and civic activities.

As Dr. Schenken now leaves the hierarchy of leadership within the American Medical Association, recognition of his efforts within and for the federation must never be forgotten.

A focus on his participant roles within the components of the Association reveals the following:

1. Member of Nebraska Medical Association House of Delegates, 1972-present.
2. Chairman NMA Commission on Governmental Affairs, 1976-1985.
3. Alternate Delegate to the AMA House of Delegates from the College of American Pathologist, 1978-1985.
4. Member AMA Council on Legislation, 1981-1985, and served as Chairman, 1984-1985.
5. Witness for the American Medical Association on numerous occasions before the United States Senate and House of Representatives.
6. Member of the Board of Trustees American Medical Association, 1985-1994.
7. In his position as an AMA Trustee, Dr. Schenken became intensely involved in the activities of the Board of Trustees through membership on the Finance Committee, 1985-1994; Executive Committee, 1986-1991; Committee on Organization and Operation of the Board, 1989-1991,

and Chairman, 1993-1994; Secretary/Treasurer of the Association, 1990-1991; and Nominating Committee, 1991-1994.

8. Throughout all of these activities Dr. Schenken never lost intimate contact with his constituency in Nebraska as reflected by his Presidency of the Metropolitan Omaha Medical Society in 1987 and his continued involvement in the House of Delegates of the Nebraska Medical Association.

Now that Dr. Schenken has completed the maximum tenure of office within the AMA, he is returning to intensified activity in his professional career as a pathologist and continued participation in the activities of both the Metropolitan Omaha Medical Society and Nebraska Medical Association.

It is customary at the annual and semi-annual meeting of the American Medical Association House of Delegates for the Nebraska delegation to gather together for dinner one evening for both comradery, and to discuss important events evolving during the conduct of the AMA House of Delegates meeting. During the last summer dinner on June 13, in Chicago, special recognition was given to Dr. Schenken, some of which was humorous but most paid in deep respect and gratitude. By far the most impressive was the following:

Tribute to Jerry Schenken

When the sun is high and the grass is green and the wind it blows offshore
When the rumors have died and the bubbles blown and the music is no more
When the hand of him that has shook so many, it tired and in need of sleep
Tis time to rendezvous once more with those whose faith we keep.

It's not how many votes you've got or the races you have won
It's not the publicity of the day that counts when the day is done
But the satisfaction that one feels in knowing you served well
And in departing have no regrets as far as you can tell

The name of the game in Nebraska is different as you well know
Your word is your bond where we come from, come rain or sleet or snow
The political game is harder to play when principle gets in your way
But integrity matters more to us than ribbons any day.

So here's to Jerry Schenken, a physician who's made us all proud
Who played the game and played it well, as well as the rules allowed
The AMA's loss in this regard will be felt as years go by
But this legacy will linger on in those who continue to try.

C.J. Cornelius, MD

Jerry, Welcome Home!

LETTER TO THE EDITOR

PHILIP S. METZ, M.D.
Chairman, Board of Examiners in Medicine and Surgery

Dear Editor:

The recent "Ask A Lawyer" publication in the Nebraska Journal regarding the disciplinary process in the State of Nebraska is a quite accurate and very helpful explanation of the disciplinary process. I would hope that the physicians of the state would read this for their own benefit so they would be able to advise their local legislators about the problems of the disciplinary system.

A careful reading of this article will show that the Board of Examiners in Medicine and Surgery really has very little input into the whole process. The Board of Medical Examiners deals only with minimum standards, therefore, the task of maintaining a very high standard of care or improving the standard of care resides with the peer review organization and committees of the various hospitals of the state.

Again, I applaud your efforts to explain a process that is very important to the professional life of the physicians of Nebraska.

Thank You.

GUEST EDITORIAL

On The Importance of Cancer Registries

JOHN H. CASEY, M.D.
Lincoln, Nebraska

There are probably few functions in most hospitals less well understood than cancer registries. Registries are viewed both by the medical staff and most other hospital personnel as mysterious places where a few individuals work diligently accumulating vast amounts of data relating to patients diagnosed and treated for cancer. Occasionally, once a year if the registry is accredited, a report complete with pie and bar graphs is issued, usually to be discarded after a thirty second perusal.

Why should this be? Is the cancer registry a futile exercise in data collection or can it really be a significant tool in the management of malignant neoplasms? I would argue strongly that a cancer registry can and must be the cornerstone of any cancer management program. With the mobility of patients and the polyspecialist approach to medicine so common today, the registry remains a central focus for following the progress of patients diagnosed and treated in the hospital setting. The registrars, who are a dedicated lot indeed, go to great lengths to follow patients wherever they might be, let them know of the registry's abiding interest in their well-being, inquire as to their current health status and remind them to visit their physician on a regular basis. It is the only hospital-based system that I know of to follow patients on such a long-term and consistent basis.

Why then, are registries often underutilized? Part of the problem, I believe, lies in the difficulty of compiling data either manually or from computerized systems which are designed primarily to enter data rather than to organize and output data in a user-friendly fashion. Many of these difficulties are being overcome with newly developed and constantly refined "turn-key" software systems available from a variety of vendors. These systems have the ability to generate sophisticated reports almost instantly. These reports can be exported to a variety of analytical systems such as Harvard Graphics if desired. These systems can aid individual physicians in the management of their patients as well as provide a look at overall cancer management in a community. For the first time, practicing physicians may begin to see the remarkable utility of the data collecting and analyzing ability of their cancer registry. For the first time, current data becomes useful on an ongoing basis, not just for the "annual report". Monthly cancer conferences just might become interesting to physicians other than pathologists. Registry data might actually affect patient management. Were this to be achieved, the time and expense of maintaining cancer registries would become worthwhile as a tool in quality patient care.

Before leaving my soapbox, I believe a word about our Nebraska Cancer Registry is in order. Since mandated by the Nebraska legislature, the Nebraska Medical Association and the Nebraska Medical Foundation have played a major role in the formation of the state registry and continues to be very actively involved in working with the Nebraska Department of Health in maintaining the high quality of data collection. I do not believe that it is an exaggeration to state that the Nebraska Cancer Registry is one of the finest and most complete in the United States. Not only does the Registry collect data submitted by hospitals, but, working with pathologists, also collects data throughout the state on newly diagnosed cases which may not necessarily be treated in a hospital setting, i.e. prostatic cancer and malignant melanoma of skin to name a few. The registry also maintains reciprocal agreements with adjoining states to track patients who might be diagnosed in those states. As in may areas, when Nebraska does something, Nebraska does it right!

As the Nebraska Cancer Registry is in its early childhood, we are only now beginning to accumulate enough cases to make the data meaningful in terms of comparisons with national data bases, such as the SEER data base, and to compare different regions of the state as to incidence and death rates for specific cancers. Even though this is a young registry, it has been invaluable in the investigation of suspected "cancer clusters" within the state.

Can one make an argument for the Nebraska Cancer Registry on economic grounds alone? The answer is a resounding YES! I can attest to the fact that the Nebraska Department of Health and university - based Nebraska researchers have been able to obtain multimillion dollar grants which may not have been unattainable had the state not had a population-based cancer registry. This is money that would have gone to other states had this registry not been in existence. Are there many other state programs which can claim the same? This phenomenon needs emphasis since, with the turnover in state legislators and recurring budget "crises", the registry becomes an easy target in budget reduction. Although I do not claim to have exact figures, the multiplier effect may be as much as 10X!

Finally, Nebraska physicians and hospitals deserve much credit for the success of the Nebraska Cancer Registry. Without the support of these institutions and individuals, as well as the Nebraska Medical Association, this registry would not be what it is today. With all of the physician and hospital "bashing" in the press, stories such as this remain, sadly, untold. The story of the Nebraska Cancer Registry is a model of cooperation of the private and public sector working together for the benefit of the populace.

I urge all readers to obtain a copy of the most recent Nebraska State Cancer Registry statistics which is available from your local hospital or the Health Department or the Nebraska Medical Association. Believe it or not, this makes for some interesting reading. You might be interested, for example, in the difference in incidence and death rates between Lancaster and Douglas counties of certain types of cancers. The Department of Health and their excellent Registry and Statistics staffs have put together a very readable and informative document from the data that you have helped to submit.

Finally, I must take this opportunity to recognize and to thank Dr. William Karrer who has labored tirelessly, on behalf of the Nebraska Medical Association and the American College of Surgeons, to develop and to maintain local registries and cancer control programs throughout the state. Bill keeps all of us involved in registry activities on our toes, and serves an inspiration to push forward and, in a very real way, to expand the frontiers of cancer control.

Let each of us take a new interest in our cancer registries, both on a local and state level, and use the information generated by these registries in the care of our patients with cancer.

GUEST EDITORIAL

Mail Order Pharmacy - An Emerging Dilemma

J. BOMAN BASTANI, M.D.
Diplomate, American Board of Psychiatry and Neurology
Diplomate, Administrative Psychiatry, Diplomate, American Board of Forensic Psychiatry
Lincoln, NE 68506

The prescription refill mailed to the offices of physicians by the central mailing houses has been a boon for the pharmaceutical industry. The cost-savings realized by these large scale dispensation of prescriptions implies competitive prices for patients. This mailing does require dispensation of substantial amounts of prescription medications to the patients with a ninety day minimum and multiple refills. Implied in this service is the belief that patient's compliance will increase as the medications are now affordable. By having enough time to call in for refills, they are assured of future medication availability. This service has been beneficial to those patients who suffer from chronic illness.

The third party payors are able to further discount these prescriptions by requiring a nominal fee per prescription from their subscribers. With this well intentioned proposal comes increasing responsibility being placed on the physician. The presence of large amounts of medications in the household at any given time carries with it concern of misuse or abuse. Analgesics and tranquilizers are two groups with strong potential for abuse.

The elderly who as a group have multiple system illnesses are benefited by these mail-in prescription savings. Unfortunately, they do not have the neighborhood pharmacist to check as far as side-effects or drug/drug interactions. The American Association of Retired Personnel encourages their members to subscribe to their mail order pharmacy as part of the offered benefits. The presence in the home of large amounts of discontinued medications is cause for concern as to the drug/drug interaction when a patient decides to restart medication without their physician's knowledge. The lack of supervision for renewal of medication in turn poses a unique problem. A standard format is a renewal prescription form mailed by these bulk prescription houses to the patient or physician's office for renewals. These renewals (up to eighteen months) are in a language open for misinterpretation.

This editorial was a result of such an event. A prescription prepared by the bulk order mail-in firm and mailed to the patient was signed and almost mailed. Closer study of the prescription revealed that "unless otherwise notified", this prescription would be good for eighteen months.

The bulk mail order firm is an outgrowth of the search to rein in the escalating medical cost. However, this is not a new concept since the Veteran's Administration had initiated this over two decades ago for their Service-connected veterans who were cared for locally in their communities. These prescription refills were for thirty days and good for six months, requiring reevaluation by their treating physician. The eighteen month unsupervised prescription for ninety day medications is a new concept which has used cost control as its rationale. Studies to evaluate the cost and benefit to the patient is worth considering. The hidden cost of lives lost resulting from overdosage, expenses from treating avoidable side-effects, toxicity resulting in hospitalization, professional liability from unsupervised prescription, and wastage of medications being prematurely discontinued due to the unpredictable course of illness add up to a sizeable cost. This cost is ultimately borne by patients and their families.

As with the practice of medicine, a large number of patients will benefit from the cost saving measures provided by this method. It is unknown what proportion of patients, who though initially helped, will suffer from the risks inherent in these bulk order mail-ins. It is time for a thoughtful debate on this subject. A study conducted by an independent institution such as the Nebraska School of Pharmacy will shed a welcome light on this growing phenomenon.

ORIGINAL ARTICLE

Treatment of Heart Failure: Update 1994

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INTRODUCTION

HEART failure is a common growing and malignant health problem. Three million Americans have heart failure and 400,000 additional patients develop heart failure each year.[1] Heart failure remains a lethal condition with median survival of 1.7 years in males and 3.2 years in females.[2] Heart failure has become the most common hospital in-patient DRG for patients greater than 65 years of age. 720,000 patients were hospitalized with congestive heart failure in 1990 at a cost of 8.9 billion dollars.[2]

Standard medical therapy for congestive heart failure has included exercise and sodium restriction, diuretics and digoxin. It is now clear that this treatment is not optimal or even adequate for most patients. Vasodilators have become the mainstay of heart failure treatment. Several experimental drugs including vesnarinone, carvedilol and bucindalol will probably have significant impact on this condition in the future.

The etiology of heart failure, especially ischemia, should be corrected whenever possible. Mechanical support with intra-aortic balloon pump or cardiac assist device may be helpful in some patients, but usually it is a bridge to transplantation or revascularization. Cardiac transplantation is the treatment of choice for suitable patients with heart failure.

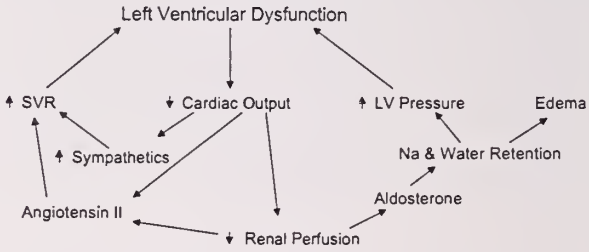
We present an overview of the new advances in the treatment of congestive heart failure. These advances will have a significant positive impact on longevity and quality of life in patients with congestive heart failure.

PATHOPHYSIOLOGY:

Understanding pathophysiology of heart failure leads to understanding treatment. Heart failure may be due to systolic or less commonly diastolic left ventricular dysfunction. Echocardiography, Doppler and nuclear studies allow differentiation. This discussion will concern systolic dysfunction but if systolic function is normal in patients with heart failure, diastolic dysfunction should be considered.

Left ventricular dysfunction precipitates a series of compensatory mechanisms (Fig. 1). Most of these mechanisms are counterproductive in heart failure.[3] The renin angiotensin system and sympathetic nervous system are activated in heart failure.

FIGURE I
Pathophysiologic cascade of heart failure - illustrating the interaction of compensatory mechanisms in heart failure.
Na = Sodium
SVR = Systemic vascular resistance



Decreased cardiac output results in decreased renal blood flow and the release of renin, which is converted to angiotensin I and then angiotensin II. Angiotensin II is harmful in heart failure because it causes: 1) direct vasoconstriction, 2) increase in sympathetic outflow, 3) increased production of aldosterone with sodium and water retention.[4] Theoretically ACE inhibitors should benefit heart failure patients and this is the case.

The sympathetic nervous system exerts harmful effect in heart failure by several mechanisms. The sympathetic nervous system induced tachycardia is probably detrimental. The cat-

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echolamines can be arrhythmogenic.[4] Increased catecholamines correlate with poor prognosis[5] and animal studies have shown myocyte necrosis secondary to catecholamines.[6] A direct toxic effect in humans may exist. Beta blockers should be helpful in patients with heart failure and supporting evidence exists and will be discussed.

Understanding the pathophysiology of heart failure is mandatory to understand current therapy. Blunting of the counterproductive compensatory mechanisms discussed here have become the mainstay of treatment.

NEW TREATMENTS OF HEART FAILURE

Conventional treatment including exercise sodium restriction and diuretics continues to have a role in the treatment of heart failure. Although there has been some controversy it is now clear that digoxin continues to have an important place in the treatment of heart failure. However we will concentrate on the new advances.

VASODILATORS:

Vasodilators have become the mainstay of the treatment of congestive heart failure. In 1986 the Veterans Administration Vasodilator Heart Failure Trial (V-Heft I) showed hydralazine and Isordil combination improved survival in patients with congestive heart failure.[7] Since that time ACE inhibitors (captopril, enalapril, lisinopril and ramipril) have established a pivotal role in the treatment of heart failure. Multiple trials have shown improved survival in patients receiving ACE inhibitors.[8-13] (Fig. 2)

FIGURE II
Trials of ACE Inhibitors in CHF

Trial	Drugs	Improved Survival
Consensus	Enalapril vs. Placebo	Enalapril
V-HEFT-II	Enalapril vs. Hydralazine/Isordil	Enalapril
SOLVD Treatment	Enalapril vs. Placebo	Enalapril

Summary of trials angiotensin converting enzyme inhibitors in congestive heart failure (CHF).

Prophylactic ACE inhibition is more controversial. The SAVE (Survival and Ventricular Enlargement) Trial evaluated captopril vs. placebo in patients with left ventricular dysfunction (ejection fraction less than 40 percent), but no heart failure.[12] Patients randomly assigned to captopril had a 19 percent reduction in mortality. The SOLVD (Study of Left Ventricular Dysfunction) Prevention Trial was a similar study.[11] There was no mortality benefit for enalapril but hospitalizations for congestive heart failure were reduced.

Prophylactic ACE inhibitor treatment for post myocardial infarction patients with congestive heart failure or left ventricular dysfunction remains unsettled. Consensus II trial also showed no mortality benefit,[13] but the ISIS IV and GISSI III trials reported at the American Heart Association meetings but not yet published appear to show benefit. The AIRE (Acute Infarction Ramipril Evaluation) Trail showed patients with acute myocardial infarction and even transient heart failure with ejection fractions greater than 40 percent had improved survival with ACE inhibitors. In our opinion these studies support early prophylactic use of ACE inhibitors in patients with left ventricular dysfunction even if asymptomatic.

In summary we feel ACE inhibitors should be given to all patients with congestive heart failure and systolic dysfunction, unless the patient has intolerance of the drug (usually renal insufficiency or cough). In these patients hydralazine and nitroglycerin combination should be used. Although the issue is in evolution, we favor ACE inhibitors for patients with ejection fractions less than 40 percent even if they are asymptomatic.

BETA BLOCKERS

The scientific rationale for the use of beta blockers in patients with heart failure has been known for years.[14] However, patient treatment data is now becoming available. The original paper by Swedberg et al demonstrating improved survival in heart failure patients treated with beta blockers was not followed up until recently.[15] The BHAT (Beta Blocker Heart Attack Trial) showed 47 percent reduction in mortality in beta blocker treated patients with heart failure[16] and the Norwegian Beta Blocker Trial also supported this concept.[17] Survival in heart failure patients treated with beta blockers is currently being evaluated by several studies including the metoprolol in dilated cardiomyopathy trial. Bucindalol[18] and carvedilol[19,20,21] are well tolerated and improve hemodyamics. Beta blockers with intrinsic sympathomimetic activity may not be beneficial in heart failure. Beta blockers must be started very slowly. For example, we start metoprolol with 6.25 milligrams daily and advanced to 25 milligrams b.i.d. over approximately two months. It is likely but unproven that these drugs will improve survival. We have significant experience with

carvedilol and find it well tolerated, and we are optimistic about its future use in heart failure.

NEW INOTROPIC AGENTS

The search for an oral inotropic agent has been frustrating. The concept of left ventricular contractility augmentation with inotropic agents is controversial.[22] Milrinone, a phosphodiesterase inhibitor increases mortality and most of this excess mortality was sudden and probably arrhythmic.[23] Enoximone is also a phosphodiesterase inhibitor with similar results. We reserved this drug for desperate situations (life isn't worth living as it is and no other measures are available). However, patients with AICD's (implantable defibrillator) may be protected against this arrhythmic death and may also be candidates for this drug. Pimobendan, a phosphodiesterase inhibitor under investigation improves exercise tolerance and heart failure symptoms but the effects on mortality are not known.[24]

Vesnarinone (OPC-8212) a quinalone derivative and weak phosphodiesterase inhibitor increases myocardial contractility without increasing heart rate or oxygen consumption. Vesnarinone improves exercise capacity and hemodynamics. This drug is unique among inotropic agents in that at 60 mg. daily it improves mortality (62 percent improvement).[25] We have extensive experience using this drug and have been impressed with the improvement in symptoms and signs of congestive heart failure in treated patients. We believe this drug will have an important role in the future treatment of heart failure.

Dobutamine is an effective intravenous IV inotropic agent. This drug is used primarily in hospitalized monitored patients. Intermittent infusion (72 hours) can cause sustained improvement for up to four weeks.[26] Many doctors now use intermittent in-hospital infusions ("dobutamine holiday"). Others have advocated home continuous dobutamine infusion.[27] This technique is associated with some risk of infection but its lack of acceptance is based largely on a fear of arrhythmia and sudden death. The only placebo controlled trial of home dobutamine was terminated early because of increased mortality in the dobutamine treatment group.[28] We have found very limited use for this technique.

ANTICOAGULATION IN CONGESTIVE HEART FAILURE

Thromboembolic events both arterial and venous are frequent complications of heart failure. Sixty percent of patients with dilated cardiomyopathy have thromboemboli necropsy: 51% have pulmonary embolus, 16% have arterial emboli and 33% have both.[29]

The propyhylactic use of anticoagulation in patients with heart failure has not been studied, but we feel prophylactic low dose anticoagulation (INR approximately 1.5) is indicated in patients with severe left ventricular dysfunction, especially if a large aneurysm is present. However the risk benefit ratio needs to be considered in each individual patient.

Standard indications for anticoagulation, i.e., atrial fibrillation, prosthetic heart valves and deep venous thrombosis should be observed. (See Fig. 3).

FIGURE III
Indications of Anticoagulation in CHF

Atrial Fibrillation
Prosthetic Heart Valve
History of DVT or PE
Systemic Embolization
EF < 30%
EF 30-40% with large LV Aneurysms

Summary of the indication for anticoagulation in congestive heart failure (CHF).
DVT = deep venous thrombosis
EF = ejection fraction
PE = pulmonary embolus

SURGERY FOR HEART FAILURE

Revascularization has above average risk in patients with severe left ventricular dysfunction.[30,31] Coronary artery bypass graft surgery appears to improve survival in patients with coronary artery disease and severe left ventricular dysfunction.[30,32,33] In addition, CHF class and qualify of life are also improved.[31] The patient selection is key in our opinion. Using the algorithm described in (Figure 4) we have been successful in revascularization for left ventricular dysfunction. In the last eight months we have done coronary bypass graft surgery on 54 patients with ejection fraction less than 35 percent. All patients survived surgery and many have improved left ventricular function (unpublished observation). The key to success is case selection, specifically using thallium to define myocardial viability. We believe the first step in the treatment of congestive heart failure is to correct ischemia if possible.

CARDIAC ASSIST DEVICES

Cardiac assist devices may be divided into two categories. They may be used as a **Me-**

FIGURE IV

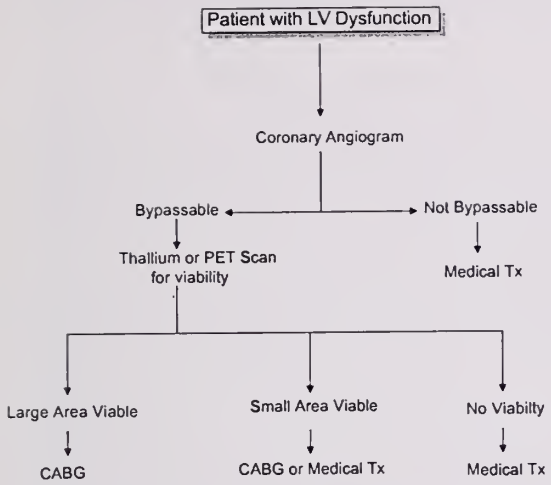


Diagram of the decision process in the evaluation and treatment of patients with LV dysfunction.
CABG = Coronary artery bypass graft surgery
Med Tx = Medical treatment

chanical bridge to buy time allowing recovery of the heart following heart surgery, massive myocardial infarction or acute myocarditis. They also allow stabilization in patients refractory to medical management awaiting heart transplantation. Second, these devices may be used as permanent **implantable devices**. These devices provide Left (LVAD), Right (RVAD) or Biventricular (BIVAD) assistance. The intra-aortic balloon pump and Abiomed are available for routine use, the other devices are experimental. Assist devices are grouped and shown in Figure 5.

CARDIAC TRANSPLANTATION

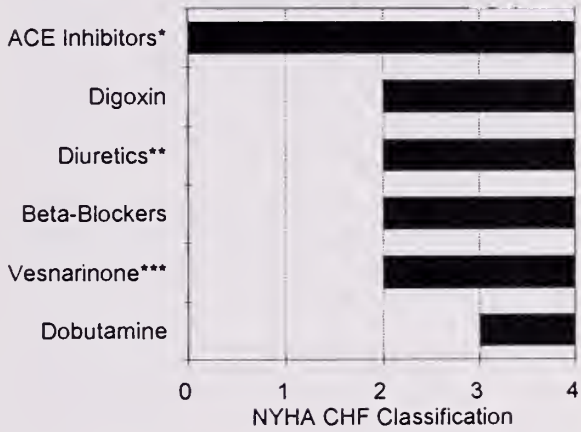
Cardiac transplantation has assumed an important role in the treatment of heart failure patients. We reviewed cardiac transplantation in detail recently in this journal.[34] Survival as well as quality of life is substantially better in patients treated with heart transplantation than in those treated medically. Our transplant patients have had survival of 92 percent at one year and 76 percent at four years.[34] The shortage of donor organs limits the procedure to only the most severely afflicted patients. Nebraska Organ Retrieval (NORS) which supplies virtually all the donor hearts to Nebraska programs reports 14 available organs per year the last eight years. Although heart transplantation may be the best treatment, medical therapy must be optimized to save these organs for those most in need (i.e. those with high mortality or symptoms refractory to medical therapy).

FIGURE V
Mechanical Cardiac Assist Devices

I. Centifugal Pump
   a. Biomedicus, Centrimed
II. Heterotopic Assist Devices
   a. Paracorporeal
      Symbion, Thoratec, Sarns, Abiomed
   b. LVAD
      Novacor, Heart-Mate
III. Orthotopic Assist Devices (Total Artifical Heart)
   a. Liotta, Akutsu, Phoenix, Penn State, Berlin, Unger Ellypsoid, Jarvik-7
IV. Nimbus Pump

Summary of mechanical cardiac assist devices.
LVAD = Left ventricular assist device

FIGURE VI



* Used in all patients with Left Ventricular Dysfunction
** Diuretics are used for correction of volume overload
*** Experimental, but we believe these drugs will be used in the future. We are currently using this drug on an experimental protocol.

Algorithm showing what we believe is the best approach to congestive heart failure now and in the future.
ACEI = Angiotensin converting enzyme inhibitor
BB = Beta Blocker
Doubta= Intravenous Dobutamine

TREATMENT OF VENTRICULAR ARRHYTHMIA IN HEART FAILURE

Ventricular arrhythmias account for nearly one half of the deaths in congestive heart failure patients.[36] Spontaneous arrhythmias are common and correlate with mortality.[37] Unfortunately suppression of arrhythmias with drugs has not improved survival. We believe tailored treatments specific to the patient may be advantageous. Beta blockers are the only drug that should be used empirically. Beta blockers decrease mortality (see discussion of beta blockers). Calcium blockers are not helpful and probably harmful. Class III agents (sotalol and

amiodarone) are probably the most effective agents but should be used in a directed fashion (either electrophysiology study or Holter directed).[38] We believe the key to this problem is correctly identifying patients at risk and treating only those patients with treatment that is proven effective. Patients with sustained ventricular tachycardia, ventricular fibrillation, and syncope with inducible ventricular tachycardia should be treated. Patients with coronary artery disease who have ejection fractions less than 40 percent and spontaneous nonsustained ventricular tachycardia, who are inducible into ventricular tachycardia at EPS study, have a high mortality.[38] Treatment of these patients is more controversial and is currently being evaluated in multiple trials. Until this data is available we treat these patients for EPS suppression. Treatment should be proven effective with EPS study or serial Holter technique. The automatic implantable cardioverter defibrillator can be used in use of drug failure.

The use of antiarrhythmic drugs in the setting of heart failure carries special hazard. Aggravation of arrhythmias (proarrhythmia) is more common in patients with LV dysfunction. These proarrhythmias can be fatal. Most antiarrhythmic agents can depress left ventricular function and worsen heart failure. Altered pharmacodynamics result in increased side effects in heart failure patients.[39]

The comprehensive treatment of heart failure patients requires evaluation of the arrhythmia including identification of patients at risk for sudden death and treatment with therapy that is effective. Correction of the hemodynamic and symptomatic abnormalities of heart failure can be wasted if the patient suffers ventricular fibrillation.

CONCLUSION

In summary, heart failure is a growing and common health problem. Treatment has changed significantly recently. We have reviewed these advances. They are summarized in Figure 6. The principles of heart failure treatment are:

1) Correct the correctable (e.g. ischemia).
2) ACE inhibitors are the mainstay of therapy.
3) Beta blockers and vesnarinone will probably have a significant role in the treatment of heart failure.
4) Heart transplantation is the treatment of choice in acceptable patients but organ shortage limits availability.

Application of these principles and optimization of medical therapy can be difficult but will result in improved patient outcome.

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ORIGINAL ARTICLE

The Promise and Challenge of Physician Profiling

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PHYSICIAN PROFILING will likely garner increasing attention as mounting pressures concerning the cost and quality of healthcare in the country continue to spark flames of reform proposals which may in time engulf America's extant system of healthcare. This nascent form of physician oversight broadly focuses on patterns of care, and the tentacles of its manifold applications extend already to far-flung activities, encompassing quality improvement, cost control, utilization review, and evaluation of provider competence. The waxing uses of physician profiling are being fueled partly by the rapidly-growing availability of pertinent data, including information-laden, third-party databases gleaned from billing-related documents.[1] Yet, a strong dose of prudence is in order in light of growing concerns of diverse nature, reaching to the quality of the practice profiles, the appropriateness of some of their uses, and, also, with respect to the propriety of disclosures of data ensconced in profiles.[2]

The term "physician profiling" has generic, rather than any specific, meaning, and refers generally to the collection, analysis and use of data associated with provider practice patterns. As a concept, this new tool for physician oversight is noteworthy for its particular emphasis on patterns of care, in place of specific clinical decisions.[3] Data are gleaned from databases, including those of proprietary, local and national origin, and these data, in turn, are used to etch a provider's pattern of practice. The practice pattern of the profiled provider, which may be an individual practitioner, a group of doctors, or even some healthcare entity such as a hospital, is expressed as a rate. The "rate" is some measure of utilization or outcome during a specific time frame for the patient population under the care of the pertinent provider.[2] The utilization or outcome rate for a particular provider can then be compared with a "norm", which may be a rate extracted from the practice patterns of other similar providers, or else based on some accepted practice guideline.

The epidemiologic technique of profiling, at least theoretically, offers a broad spectrum of potential applications. Information culled from the use of this analytic tool may potentially enable purchasers, consumers, regulators and policymakers to make useful, valid comparisons of providers with respect to such vital dimensions as cost, utilization and the quality of care.[4] Especially if used discreetly, information emanating from profiling may be of value in assessing provider performance and revealing extant problems adversely impacting the quality of care. Although some practitioners may tend to look askance at what may be judged yet another cudgel of onerous scrutiny, it should be borne in mind that profiling may have value in reducing aberrant practices, including overutilization and underutilization of services, in a relatively unobtrusive manner. It may further have utility extending to the realms of granting clinical privileges, and with respect to certification and recertification of physicians.[1] Profiles, indeed, have already been developed, broadly intended to assist with: provider education; physician selection; physician compensation; and identification of marketing opportunities for providers.[5] Ultimately, profiling may have educational as well as practical economic value possibly leading to overall improvement in the quality of care while concomitantly achieving cost-consciousness.[2,6]

Regardless of whether one is sanguine or dour about the future prospects of profiling, the fact remains that momentum certainly seems to be growing in support of profiling in particular, and reform measures in general, which may deflate healthcare cost inflation while safeguarding the quality of care. As such, profiling, at least to some measure, is likely cemented to the landscape of healthcare in America. The task at hand, really, is to dissect profiling, examine its components scrupulously, and attempt to structure or perhaps reshape it in a way reasonably designed to

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avoid, or at least ameliorate, potential abuses. In this vein, it is noteworthy that the foundation of profiling, in terms of its validity and relevance, will likely topple, if the underlying data are flawed.

Data-related issues, germane to profiling, are legion in number, and trenchant in importance. For example, sample size issues may be raised. Profiling is linked closely to comparisons. Comparative studies, to be meaningful, require a showing that any observed differences are significant statistically, rather than being associated with random variation.[4] Unless an outcome of interest occurs often, or a service is provided frequently, the number of observations in a particular profile may be insufficient to rule out the possibility that observed differences may be attributable to chance.[2] A further data-relevant issue, of core concerns, relates to the reality that databases often used at present for profiling may be far from ideal for profiling purposes, in part because the databases were created for other purposes. At this time juncture, profiling is based primarily on data collected from ponderous, administrative databases, including particularly claims files and medical records (especially hospital discharge data and inpatient records).[2] Databases of this sort are not necessarily in close harmony with the needs of profiling.[1] Since the data were not collected specifically to assess performance, they may have little to offer in terms of information about medications, laboratory results, preventive services, postoperative care, or patient compliance. The administrative databases now widely used in profiling, in sum, do not really reveal the full range of what providers actually do. And a salient issue which emerges is whether databases, such as the administrative ones now in vogue, developed for purposes not directly relevant to measuring utilization or outcomes of care, are proper and sufficient for purposes of profiling. It would seem that, unless extant data-related concerns are addressed carefully, the future promise of profiling is limited.

Although physician profiling, at least as practiced presently, seems to pose severe problems and challenges, its possible usefulness in a reformed healthcare system should not be ignored. Critical, but level-headed, thinking on the subject appears to be called for, with an eye focused on changing profiling from its inchoate form to a more refined one more nearly compatible with the particular goals of profiling. It may well be possible to resculpt the present body of profiling into a form holding reasonable promise for fostering improvements in the quality of care or perhaps with respect to its cost-effectiveness. Especially because of the close nexus between the potential efficacy of profiling and the underlying database drawn upon, rapt attention directed towards data-related issues should be assigned a high priority. Difficult, and quite contentious, issues concerning confidentiality and public access to profiling information must be grappled with, as well.[2] The public has a legitimate need to know about the competence of providers; in this vein, some consumer-oriented advocates may embrace public availability of profiling data as a way to protect the public from poor-quality providers. Yet, sloppy, inappropriate release of sensitive information may have fractious results, and may be especially ill-advised if the pertinent data do not have undoubted validity. Finally, despite existing real deficiencies, there is nonetheless a thriving industry engaged in the marketing of profiling information to third-party payers and employers.[1] These commercial enterprises are not monitored presently; and there is obvious potential for abusive uses of the information being peddled. The physician community needs to devote its immediate attention to the careful study of physician profiling, or else present abuses may continue untreated and the luring potential of profiling may lapse into denigration.

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FRACTURE OF THE MONTH

Treatment of Humeral Diaphyseal Nonunions Using Fibular Allograft and Compression Plating

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INTRODUCTION

Fractures of the humerus at the diaphyseal or metaphyseal levels have a high rate of union and good clinical results with appropriate treatment.[1,2] Nonunions are uncommon but extremely difficult to manage. The traditional method used to treat this complication has been compression plating with iliac crest bone grafting. We present in this report a relatively new technique to manage humeral shaft nonunions using an intramedullary fibula allograft and a compression plate.

CASE REPORT

D.B. is a 59-year old white male who fell from a truck and sustained an isolated closed comminuted right humerus fracture at the junction of the middle and distal one-third. The patient was treated with closed reduction and intramedullary rodding using a Siedel nail. Postoperatively, he was kept in an immobilizer and active motion at the shoulder and elbow was allowed as tolerated. Seven months postoperatively, he still experienced pain at the elbow. Radiographs revealed a nonunion at the fracture site. Electrostimulation was recommended and begun at this point.

Nine months postoperatively, the patient was involved in a second automobile accident, breaking the electrostimulator unit and sustaining a Grade 1 injury to the left acromioclavicular (AC) joint. Electrostimulation was restarted, and, after recovery of his AC joint injury, he was started on crutch ambulation to load the nonunion site. He was referred to the Shoulder Service after persistence of pain and limited function.

Initial examination revealed marked tenderness as well as gross motion at the fracture site; the distal fragment could be rotated around the Siedel nail. External rotation strength was 3+/5, active forward flexion to 65 degrees, glenohumeral abduction to 45 degrees. Neurological examination was normal. Radiographs revealed an atrophic nonunion at the midshaft of the humerus (Figures 1A and 1B). In addition to the nonunion, our impression also included a rotator cuff tear. We recommended removal of the IM nail, fibular allograft, compression plating, and repair of the rotator cuff tear.

During the operation, the IM rod was removed and the rotator cuff tear was identified at the previous nail insertion site. The nonunion site was taken down and a fibular allograft was inserted in the IM canal. A compression plate was applied laterally after the demineralized bone matrix graft was added to the fracture site. The rotator cuff tear was then repaired.

The patient was started on passive ROM exercises for three weeks, followed by active assisted ROM exercises for three weeks, and then an active rotator cuff strengthening program.

RESULTS

At seven months postop, the patient was pain-free and not taking any narcotic analgesic medications. Examination revealed active forward flexion to 90 degrees, passive flexion to 160 degrees, and active abduction to 90 degrees. Radiographs revealed solid union of the fracture (Figures 2A and 2B).

At nine months postop, active forward flexion improved to 130 degrees, active abduction to 70 degrees, and external rotation to 45 degrees. He lacked about three spinal levels of internal rotation. The patient is still currently working with a physical therapist on the range of motion and strengthening of his rotator cuff muscles. He has returned to his job as a truck driver.

DISCUSSION

Coventry and Laurnen reported on a variety of techniques to manage humeral shaft nonunions including: a dual-onlay tibial graft, external fixation across the fracture site using the Roger-Anderson device (for an infected nonunion), and the use of an IM rod inserted through an IM fibula allograft inserted into the humeral shaft.[3] They reported success with the former two techniques

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FIGURE 1A & FIGURE 1B

AP and lateral radiographs of the right humerus. There is a radiolucency surrounding the Siedel nail and an atrophic nonunion at the fracture site.

FIGURE 2A & FIGURE 2B

AP and lateral radiographs of the right humerus five months after insertion of the fibular allograft and compression plating revealing evidence of bridging callus formation and incorporation of the allograft.

but the latter construct failed to provide bony union.

Jupiter advocated a method using a medial surgical approach, a vascularized fibular autograft, and an anterior compression plate to obtain union in four obese patients with atrophic synovial nonunions.[1] All their patients had undergone previous operations to obtain union. All four nonunions healed at an average follow-up of 27 months.

Trotter and Dobozi obtained bony union in all five of their elderly patients with osteoporotic bones using compression plating and adjunctive methylmethacrylate injected either into the nonunion site or into the screw sites prior to actual screw insertion.[2] However, bone cement may compromise the endosteal blood supply and may be detrimental to bony healing, especially if it extrudes into the fracture site.

Wright et al recently reported on successful union in eight of nine patients treated using the protocol presented in this report.[4] Mean time to union was 3.5 months. Their biomechanical study revealed that, in general, the screw pullout strengths of the quadricortical fixation through the fibula allograft and the humerus were compatible with those of cementaugmented bicortical screw fixation through the humerus only, and were significantly stronger than that of bicortical fixation alone.

Factors that have been known to be associated with humeral shaft nonunion include: obesity, infection, smoking history, osteoporosis, previous internal fixation, inadequate immobilization, distraction, transverse fracture configuration, and significant soft tissue injury.[1,2,3,4] The majority of authors also agree that the most frequent location of a fracture that fails to heal is at the junction between the middle and distal one-third of the shaft.[5,6] Most authors attribute this to injury to the primary nutrient vessel to the humerus which enters the shaft along the medical border near the mid-portion of the humerus.[5,6,7,8]

Our patient had several factors that placed him in the higher risk group of a nonunion complication: elderly age, smoking history, fracture site at the junction of the mid- and distal one-third of the shaft, and a previous internal fixation.

The main impetus in using the method presented in this report was that the fibula allograft served as a rigid intramedullary support across the fracture site. In doing so, the graft enhanced screw fixation by providing the surgeon two additional cortices of fixation at each subsequent screw purchase. The fibula allograft provided a larger endosteal surface area to accelerate bony union. The construct was felt to be stable enough to allow early range of motion exercises. We feel that all these factors contributed to our patient's good clinical result.

Disadvantages of using a fibula allograft include the small risk of transmission of infectious organisms such as the HIV virus and the hepatitis B virus. These risks are significantly lessened with the use of modern preservation and sterilization techniques. These techniques also reduce the host-donor response by reducing the antigenicity of the graft. However, the osteogenic (osteoinductive) capacity of the allograft may be reduced as well.

Along with the other traditional methods, we feel that this technique will enhance the surgeon's armanentarium in the treatment of this most difficult complication of humeral shaft nonunion. We have currently applied this technique successfully in approximately 15 consecutive nonunions of the humerus.

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PERINATAL PAGE

Newer Strategies in the Prevention of Hyaline Membrane Disease

LYNNE D. WILLETT, M.D.

HYALINE membrane disease and premature birth accounts for a significant expenditure of health care resources. Prevention is worth a pound of cure. This article will focus on newer therapies being investigated to stimulate pulmonary maturity and prevent respiratory distress syndrome or hyaline membrane disease (HMD) in premature infants.

Glucocorticoids

Of the many agents that have been shown to enhance lung maturation, the effectiveness of glucocorticoids has been the most extensively documented, both clinically and in animal models. It is known that these steroids accelerate many aspects of lung maturation including differentiation of the terminal airways and synthesis of pulmonary surfactant. Meta-analysis of published clinical studies relating to antenatal administration of glucocorticoids reveals that treatment is primarily effective before 34 weeks of gestation and when delivery occurs within 1-7 days of the first dose. Despite some reports to the contrary, the majority of studies show that steroids are effective in both male and female fetuses.[1,2]

Questions have been raised as to whether steroids are effective in infants <30 weeks gestation. Large series examining this group of patients are not available. In examining smaller studies of infants who were born 1-7 days after initial steroid treatment, the data are reasonably consistent. The mean incidence of HMD in the control infants is about 60% whereas it was 37% in the treated group. In infants greater than 34 weeks gestation, the incidence of HMD is small, thus proving statistical significance in any one treatment study would be difficult. Nonetheless, in the face of known fetal lung immaturity (i.e. immature LS ratio) the effectiveness of prenatal steroids in this age group would presumably be the same.

Some controversy also exists as to whether an increased risk of maternal infection is possible when mothers with ruptured amniotic membranes are treated with antenatal steroids. Most recent studies have tended to suggest that steroids are effective in cases of ruptured membranes and do not predispose the recipient or neonate to infection. Steroid therapy is associated with few complications. Although one study suggested the use of steroids may be problematic in cases of severe hypertension with proteinuria, this has not been the general experience. Steroids may, however, complicate the management of women with diabetes.

In summary, the benefits of antenatal glucocorticoids include a reduced incidence of HMD by 40-60%, and a decrease in intraventricular hemorrhage, necrotizing enterocolitis and overall mortality as well as a trend toward better neurologic and intellectual function at follow-up. The drugs themselves are cheap and individual studies indicate a decrease in duration and cost of hospitalization.

Thyrotropin Releasing Hormone

Although steroids are effective in reducing the incidence of HMD, there is a residual group of infants who develop respiratory distress syndrome despite optimal glucocorticoid therapy. For this reason, a number of centers are evaluating the effects of a combination of thyrotropin-releasing hormone (TRH) and glucocorticoids. Synergistic enhancement of lung phospholipid synthesis by thyroid hormones and steroids has been observed in animal studies. TRH crosses the placenta readily from mother to fetus, unlike other thyroid hormones.

In a collaborative trial at 4 medical centers, women with threatened preterm delivery at less than 32 weeks gestation were randomly assigned to receive either betamethasone & TRH or betamethasone alone.[3] While the addition of TRH did not significantly reduce the total incidence of HMD or severe HMD in a very-low-birthweight babies, it was associated with a significantly lower rate of chronic lung disease (bronchopulmonary dysplasia or BPD) - 18% vs. 44%. The TRH group also experienced lower mortality and less continuous need for oxygen. Adverse affects were seen in 17% of women with nausea, vomiting and flushing. There was a 2 fold rise in thyroid hormones and prolactin noted in cord blood followed by transient suppression of thyroid function persisting 2-10 days after birth. All studies were, however, performed without surfactant therapy and are being repeated with the addition of surfactant.

Although antenatal TRH plus glucocorticoids

appears to be beneficial, routine use of this hormone combination cannot be recommended until further studies are performed.

Replacement Surfactants

Surfactant for infants with or at high risk for HMD is an effective therapy, as demonstrated by multiple excellent clinical trials. Surfactant decreases 28-day mortality from HMD and overall mortality by 30-40% in infants in the 750-2000 gram weight ranges. Surfactant treatments also decrease air leaks (pulmonary interstitial emphysema and pneumothorax) and probably decrease the severity of BPD. Thus far, they have not been proven to change the incidence of other common complications of prematurity - patent ductus arteriosus, intraventricular hemorrhage and necrotizing enterocolitis.[4,5,6]

The choice of synthetic or animal surfactant for clinical use makes little difference in terms of death as an outcome, although surfactants with proteins permit more rapid decreases in oxygen and ventilatory pressures. There are two types of surfactant available for use. The first are the protein-free surfactants assembled from phospholipids and lipid or detergent-based spreading agents (Exosurf Neonatal[R]). The second are the animal surfactants modified by organic solvent extraction (Survanta[R], Infasurf[R]). Exosurf, a completely synthetic, protein free surfactant, was approved for the treatment of HMD in 1990. Survanta, approved for use in 1991, is an extract of animal bovine lungs, while Infasurf is an extract of calf lung lavage fluid. They both contain only the low-molecular-weight, hydrophobic surfactant proteins SP-B and SP-C. The surfactant protein SP-B is the critical protein causing acute biophysical effects on the surfactant-deficient lung. This protein, when mixed with lipids, improves lung volume, increases lung compliance and decreases pulmonary edema.

Once a surfactant enters the preterm lung, it can mix with endogenous surfactant components already in the lung to yield a surfactant superior to the one initially used to treat the HMD. However, other substances in the alveolar fluid such as proteins, amino acids, and unsaturated lipids, can inactivate the surfactant. The net balance between the original quality of the surfactant, activation and inactivation contributes to the infants quality of response to the surfactant. Uniformity of distribution and response appears much better with prophylactic treatment versus rescue therapy, even though some infants may inadvertently be treated who would not have developed disease in this protocol.[7,8] The worst distribution of surfactant comes with long infusion times ie. over 30 minutes.

Currently head to head trials are in progress comparing the effectiveness of available surfactants. While the administration techniques for surfactants presently in use are effective, the doses and techniques may not be optimal. Aerosolization, for example, may prove to be safer and equally or more effective.

Both animal and clinical studies indicate that while both antenatal glucocorticoids and postnatal surfactant are effective in improving lung function, the combination of the two is better than either alone.[9] Glucocorticoids, when given to women at risk of preterm delivery can not only decrease the incidence of HMD but also improve responses to surfactant treatment. A recent randomized study revealed that when therapy with steroids and postnatal surfactant is compared to surfactant alone, there is a reduction in the incidence of HMD and intraventricular hemorrhage as well as decreased time on the ventilator and on oxygen.

Recommendations

In threatened premature labor prior to 34 weeks of gestation when fetal lung maturity is unknown or when the lungs are documented to be immature, antenatal glucocorticoids should be administered if it is anticipated that there will be at least a 12 hour interval between the time of initial hormone administration and delivery.

This should be followed by surfactant therapy if the infant meets established criteria. Selective use of combined hormonal therapy may be appropriate in high-risk situations.

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ASK A LAWYER

1. What does Nebraska's health care provider lien law enable a health care provider to do?

The lien law, codified at Neb. Rev. Stat. § 52-401 (Reissue 1988), enables physicians, nurses, or hospitals which provide professional services to an injured party to obtain a lien upon any sum which is awarded to that injured person as the result of a settlement or court judgment against the party which caused the injury. Such liens are not valid, however, against anyone coming under the Nebraska Workers' Compensation Act.

2. How does a health care provider take advantage of the law?

To take advantage of the lien law, a health care provider must serve a written notice upon the party from whom damages are claimed. The notice should state the following:

1) the name of the physician, nurse, or hospital who claims a lien for services provided,
2) the amount due, and
3) the nature of the services provided.

Whenever an action is already pending in court for the recovery of such damages, however, it is sufficient for the health care provider to file the notice of such lien in the pending action.

3. Does a health care provider have an obligation to share in the cost of attorney fees when that lien is satisfied as a result of litigation between the injured party and the wrongdoer?

No. A physician, nurse, or hospital which takes advantage of the lien law is not then obligated to contribute toward the injured party's attorney fees, even when the litigation brought by the injured party against the injuring party resulted in satisfaction of the health care provider's lien.

In a recent court decision. In re Guardianship & Conservatorship of Bloomquist, 2 Neb. App. 756 (1994), the State of Nebraska adopted the rule that, although the initial amount that is recovered by the injured party must be reduced by the amount of the injured party's attorney fees, the remainder may be used to satisfy the health care provider's lien. The health care provider is not, then, responsible to contribute any portion of the money to which it is owed toward attorney fees.

The court in the Bloomquist case noted that there was nothing in the lien law which expressly required health care providers to pay attorney fees simply because subsequent litigation incidentally satisfies the health care provider's lein.

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"Ask a Lawyer" is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the **Nebraska Medical Journal**. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen, with the assistance of UNL College of Law student Jane Kemper of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

ALLIANCE

Report of the 1994 AMAA House of Delegates

CARMEN KLEAGER
President-elect NMAA

The 1994 AMAA House of Delegates was convened in Chicago on June 12th, 1994 by President Mary Hanson. The colors were presented by the U.S. Navy Color Guard of Great Lakes, IL.

Business conducted included hearings held by the following committees: Reference Committee A, regarding organizational affairs, Reference Committee B, regarding health issues, and the Reference Committee on issues regarding bylaws changes. Following the hearings by the respective committees, the issues with their recommendations were brought before the House of Delegates for a vote. The following is a summary of the issues and outcomes.

Reference Committee A —
Organizational Affairs:

1. Proposed Budget — 1994-95 budget of $1,498,602 was adopted.
2. A United Fiscal Year — Changing the fiscal year of the AMA (currently from July 1 to June 30) to coincide with the calendar year dates used by the AMA. This resolution was referred to the Strategic Planning Task Force for additional study.

Reference Committee B — Health Issues:

1. Resolution regarding promotion of education about the dangers of tobacco use was passed.
2. Resolution regarding education on the handgun and assault weapon issue. This issue encourages education about the safe use and storage of firearms and also supported Alliance efforts towards the passage of legislation to restrict the sale and ownership of large-clip, high rate-of-fire automatic and semi-automatic weapons. This resolution passed.
3. Resolution regarding the fact that gambling could be addictive, and that the AMAA should recognize this as an issue to be concentrated on was defeated. Delegates voted not to designate this as an issue of the AMAA at this time because the majority felt that we should concentrate on the current causes.
4. Resolution regarding the promotion of programs to educate parents and children about the harmful effects of "gangsta rap" passed.

Reference Committee on Bylaws:

1. A change in the deadline for delegate allocation was defeated. The current policy stands.
2. A resolution passed that would not permit proxy voting for the AMAA House of Delegates, Board of Directors, Executive Committee, Standing Committees, or other committee meetings.
3. A resolution that would all give State Alliances/Auxiliaries more flexibility in chartering "county" organizations was referred to the Bylaws Committee for further review. This resolution was presented because practice options have grown with more managed care situations. These practices may cross county and even state lines offering different opportunities to form Medical Alliances.
4. A resolution for the gender-neutral term of "Chair" rather than "Chairman" passed.
5. A resolution that requested a total bylaws review passed.
6. A resolution that asked for a change from "Robert's Rules Order" to "Davis Rules" for parliamentary authority was defeated.

Other items of business included two-minute-in-length state reports. Past-President Barbara Bohi highlighted the happenings in Nebraska for her term as President. It was a very credible report, and we were proud to be from her state. She was presented with the "One-Plus" awards for Nebraska's increase in membership as well as being recognized for adding a Resident Physician/Medical Student Spouse Group. Recognition and awards were also given to Dodge County for the third greatest percentage in-

crease in AMA-ERF contributions and to Buffalo County for the fifth greatest percentage increase in AMA-ERF contributions. These were very significant achievements.

Elections for the 1994-95 year were held. Barbara Tippins from Georgia was elected to the office of President, with Sharon Scott from Oregon becoming President-Elect. Colleen Adam from our state (Adams County) will chair the Bylaws Committee for the current year. The field director assigned to Nebraska is Johnnie Amonette from Tennessee. We anticipate a visit from her, possibly at our Fall Meeting.

Featured speakers for the session included the world-renowed poet and author, Maya Angelou, the nationally known political commentator Fred Barnes who is a regular panelist on "The McLaughlin Group," and Jeff Goldsmith, PhD and author of "Can Hospitals Survive?: The New Competitive Health Care Market." Other speakers included Joseph Painter, MD, president of the AMA, and Nancy Dickey, MD, board member of the AMA.

Attending the 1994 AMAA House of Delegates Session from Nebraska as state delegates were Barbara Bohi, Immediate Past-President, Sally Semm, President, Carmen Kleager, President-Elect and Linda Shafer, Vice-President. Also attending as national delegates were Colleen Adam, Field Director, and Donna Stone, Nominating Committee and AMA-ERF Committee. We sincerely thank you for the opportunity of representing the NMAA at the Annual House of Delegates Session.

WELCOME NEW MEMBERS

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COMING MEETINGS

CREIGHTON UNIVERSITY

AUGUST 31, 1994 — New Management Options in Bipolar Disorder - St. Joseph Center for Mental Health - 10:00 am - 12:00 pm.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

SEPTEMBER 29, 1994 — Update in Obstetric Ultrasonography, Marriott Hotel, Omaha, NE.

SEPTEMBER 30 - OCTOBER 1, 1994 — Day With the Perinatologists - Marriott Hotel, Omaha, NE.

OCTOBER 4, 1994 — T.T. Smith Lecture - Boys Town National Research Hospital Auditorium.

OCTOBER 7, 1994 — Fifth Annual: Come Home to Creighton, Skutt Student Center, Creighton University, Omaha, NE.

OCTOBER 8, 1994 — Cardiology Program - Henry Doorly Zoo.

OCTOBER 15, 1994 — Residents Teaching Skills Program, Criss Building, Creighton University, Omaha, NE.

OCTOBER 19, 1994 — Distinguished Lecture Series, William J. Hoskins, M.D.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite 2130, Omaha, NE 68131.

MAYO FOUNDATION

OCTOBER 16, 1994 and OCTOBER 30, 1994 — Problem Solving in Hypertension, Mayo Foundation, Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

OCTOBER 29, 1994 — Update and Case Reviews in Otorhinolaryngology - Head & Neck Surgery, Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

NOVEMBER 3-4, 1994 — Mayo Clinic Ob/Gyn Clinical Review, Mayo Foundation Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

NOVEMBER 12-13, 1994 — Monitoring Neural Function During Surgery, Mayo Foundation Rochester, Minnesota. Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

FEBRUARY 1-8, 1995 — Update in Clinical Neurophysiology, Mayo Clinic, Rochester, MN.

FEBRUARY 4-8, 1995 — Selected Topics In Internal Medicine, Silverado Resort, Napa Valley, CA.

FEBRUARY 9-11, 1995 — Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management, Silverado Resort, Napa Valley, CA.

MARCH 24-26, 1995 — Advances in Clinical Anesthesiology, Silverado Resort, Napa Valley, CA.

APRIL 6-9, 1995 — 2nd Int'l Conference on the Medical Aspects of Telemedicine & 2nd Annual Mayo Telemedicine Symposium, Mayor Clinic, Rochester, MN: Mayo Clinic Jacksonville, FL; Mayo Clinic Scottsdale, AZ. Contact: Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: Toll Free 800-323-2688.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

SEPTEMBER 15-17, 1994 — Fall Session, Cornhusker Hotel, Lincoln.

APRIL 27-30, 1995—Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

UNIVERSITY OF NEBRASKA MEDICAL CENTER EMERGENCY MEDICAL SERVICES

AUGUST 22-23, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA Catagory I, 14.5 Prescribed Hours AAFP. Fee: $195.

SEPTEMBER 9-10, 1994, FRIDAY, SATURDAY — Advanced Trauma Life Support (ATLS). Good Samaritan Hospital, Kearney, Nebraska, Target Audience: Physicians, Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.0 Hours ACEP Category I. Fee: $550.

SEPTEMBER 12, 1994, MONDAY — Advanced Cardiac Life Support (ACLS) Renewal, University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.00

SEPTEMBER 13, 1994, TUESDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

SEPTEMBER 13, 1994, TUESDAY — Pediatric Advanced Life Support (PALS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses. Credit: 4 Hours AMA Category I. Fee: $50.

SEPTEMBER 15-16, 1994, THURSDAY-FRIDAY— Trauma Nurse Core Course (TNCC). Regional West Medical Center, Scottsbluff, Nebraska. Target Audience - Nurses. Credit: 18 CECH's of BCEN's Category of Clinical. Fee: $210 - Non-ENA Members, $174 - ENA Members.

SEPTEMBER 22-23, 1994, THURSDAY-FRIDAY— Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.0 Hours ACEP Category I. Fee: $550.

SEPTEMBER 24, 1994, SATURDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee $110.

SEPTEMBER 24, 1994, SATURDAY — Advanced Trauma Life Support (ATLS) Reverification, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 3 Hours AMA Category I, 3 Prescribed Hours AAFP, 3 Hours ACEP CAtegory I. Fee: $185.

OCTOBER 3-4, 1994, MONDAY-TUESDAY — Advanced Live Support in Obstetrics (ALSO). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Family Physicians, Obstetricians, General Practitioners, Emergency Physicians, Surgeons, Nurse Midwives, Obstetrical Nurses. Credit: 14 Hours AMA Category I, 16.0 Prescribed Hours AAFP. Fee: $300 - Physicians, $225 - Nurses.

OCTOBER 10-11, 1994, MONDAY-TUESDAY— Pediatric Advanced Life Support (PALS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses. Credit: 13 Hours AMA Category I. Fee: $175.

OCTOBER 20-21, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA CAtegory I, 14.5 Hours Prescribed Hours AAFP. Fee: $195.

OCTOBER 24-25, 1994, MONDAY-TUESDAY— Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.9 Hours ACEP Category I. Fee: $550.

OCTOBER 31 - NOVEMBER 1, 1994, MONDAY-TUESDAY — Trauma Nurse Core Course (TNCC), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience - Nurses. Credit: 18 CECH's of BCEN's

Category of Clinical. Fee: $210 - Non-ENA Members, $175 - ENA Members.

NOVEMBER 7-8, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

DECEMBER 1, 1994, THURSDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.

DECEMBER 2, 1994, FRIDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

DECEMBER 2, 1994, FRIDAY — Pediatric Advanced Life Support (PALS) Instructor, University of Nebraska Medical Center Campus, Omaha, Nebraska. Credit: 4 Hours AMA Category I, 4 Hours Prescribed Hours AAFP. Fee $50.

For further information: Contact Cindy Hanssen, University of Nebraska Medical Center, Center for Continuing Education, 600 So 42nd Street, Omaha, Nebraska 68198-5651. Call (402) 559-5919 or use our toll free MD ADVANTAGE NUMBER AND ASK FOR CONTINUING EDUCATION (1-(800)652-1095 NATIONWIDE. FAX NUMBER (402) 559-5915.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

AUGUST 19-21, 1994, FRIDAY-SUNDAY— Midwest Breast Imaging Conference, Omaha Marriott Hotel, Omaha, Nebraska. Target Audience: Radiologists, Primary Care Physicians, Technologists. Fee: $250 before 7/1/94. $300 after 7/1/94 ($150/$200 for Technologists).

SEPTEMBER 17, 1994, SATURDAY — 7th Annual Internal Medicine Update, University of Nebraska Student Union, Lincoln, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER, Fee: $45.

SEPTEMBER 26, MONDAY, — OCTOBER 1, 1994, SATURDAY — Emergency Medicine, 1994, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

OCTOBER 7, 1994, FRIDAY AFTERNOON — University of Nebraska College of Medicine Alumni Day (in conjunction with the Omaha Midwest Clinical Society Meeting), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: College of Medicine Alumni.

OCTOBER 8-12, 1994, SATURDAY - WEDNESDAY — North American Society of Pediatric Gastoenterology and Nutrition, Westin Galleria Hotel, Houston, Texas. Target Audience: Physicians and scientists interested in the field of pediatric gastoenterology and nutrition.

OCTOBER 14-17, 1994, FRIDAY EVENING-MONDAY — Advanced Curriculum on Women's Health - Part II, Adam's Mark, Philadelphia, Pennsylvania, Target Audience: Primary Care Physicians.

OCTOBER 19, 1994, WEDNESDAY — Advanced in Acid Related Diseases, Omaha Marriott, Omaha, Nebraska. Target Audience: Primary Care Physicians.

OCTOBER 22, 1994 — Transfusion Medicine, University of Nebraska Medical Center. Target Audience: Surgeons and Anesthesiologists.

NOVEMBER 12, 1994, SATURDAY— Evaluation and Management of the Swollen Extremity, UNMC, College of Nursing, Omaha, Nebraska. Target Audience: Primary Care Physicians and Nurses.

DECEMBER 1-3, 1994, THURSDAY-SATURDAY — Obstetrics and Gynecology Conference, Bally's, Las Vegas, Nevada. Target Audience: Primary Care Physicians, Obstetricians and Gynecologists. Fee: $275.

MARCH 5-10, 1995, SUNDAY-FRIDAY — 15th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MARCH 27-APRIL 7, 1995, 11 DAYS — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

APRIL 24-MAY 5, 1995, 11 DAYS — Family Practice Review , Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

JUNE 2-3, 1995, MONDAY-TUESDAY— Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

JUNE 9-10, 1995, FRIDAY-SATURDAY — 3rd Annual Diagnostic Dilemmas in Women's Health Care, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Physician Assistants. Fee: $200.

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GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

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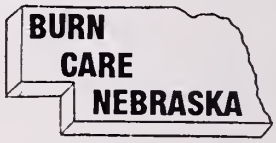

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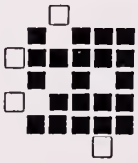

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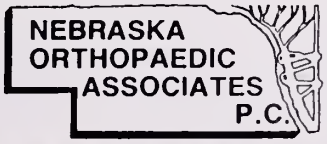

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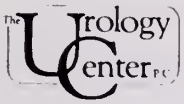

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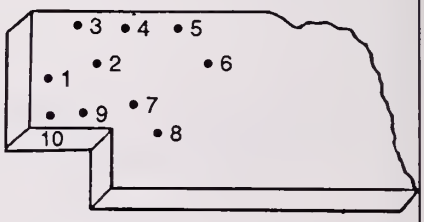

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Name	Address		Birth Date / /
City	State	Zip	Rent/House Payment $
Previous Address	City	State	Zip
Employer/Group	Address	Social Sec. # - -	
Bus. Phone ( )	Income $	No. of years	
Home Phone ( )	Other Income	Income from alimony, child support, or separate maintenance payments need not be revealed If you do not choose to have it considered as a basis for repaying this obligation $	

Name of nearest relative not living with you | Address | City | State | Zip | Relationship

Financial Institution | Address | City | State | Zip | Savings Acct # | Checking Acct. #

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City	State	Zip	Rent/House Payment $
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Account Number	Balance $	Payment Address

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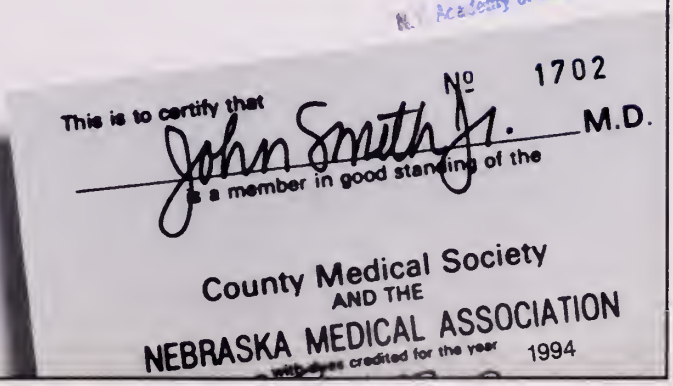

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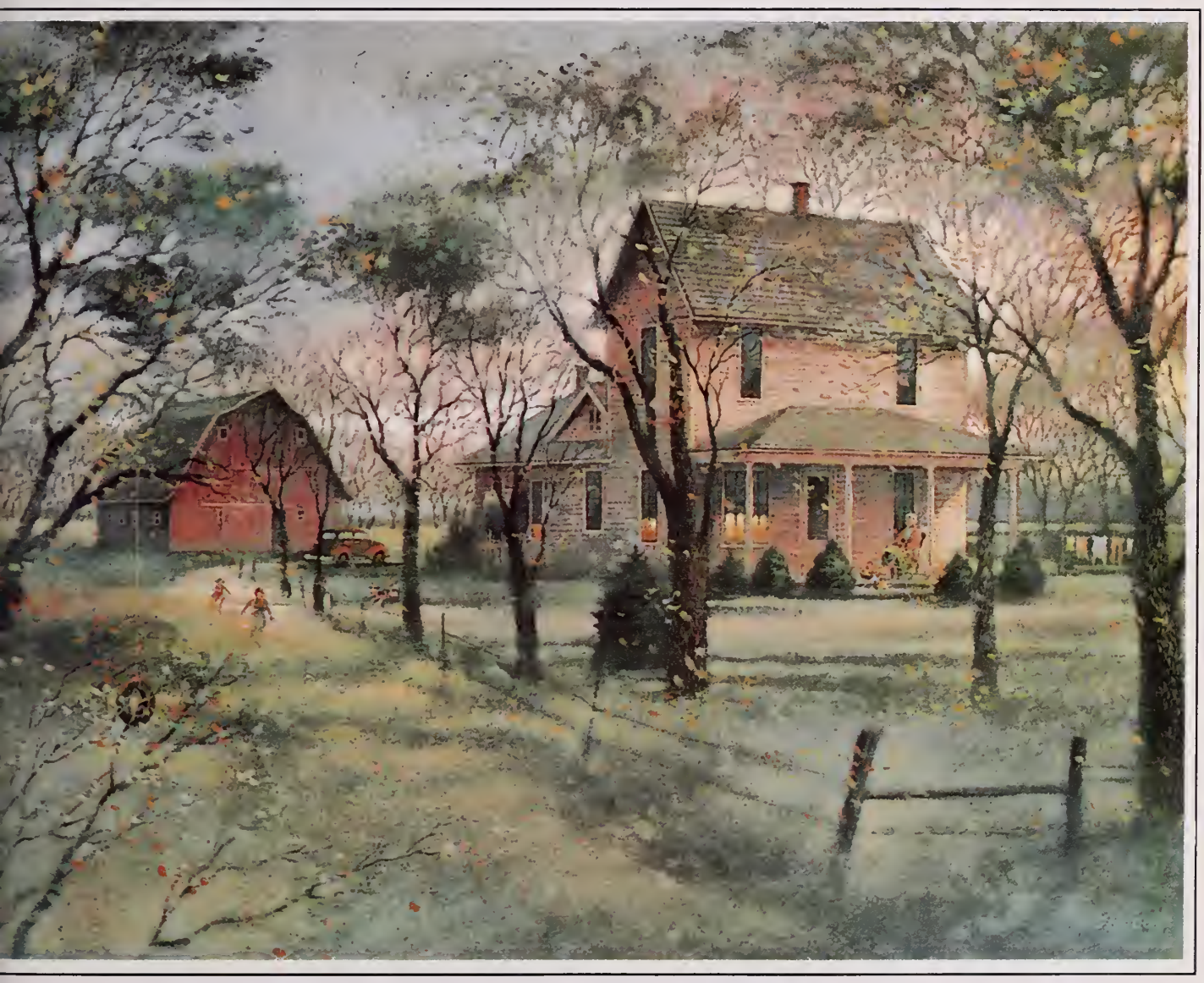

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David Silverberg, MD,
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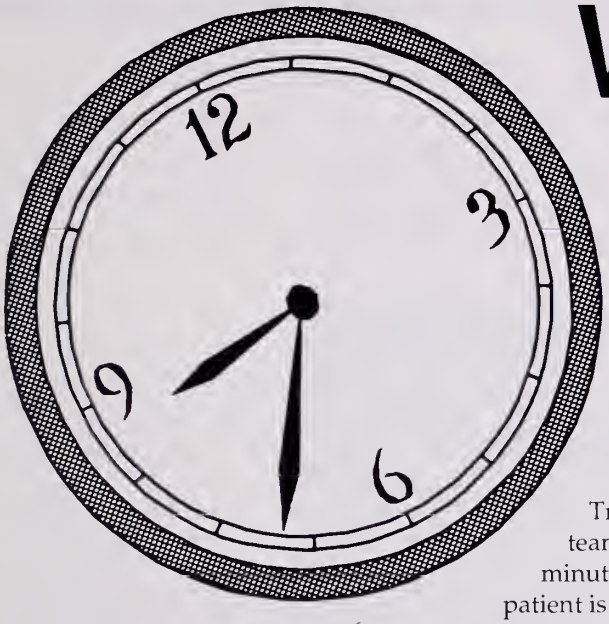

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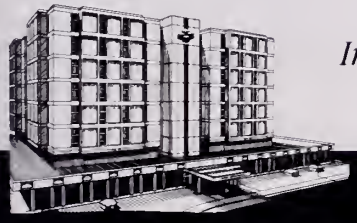

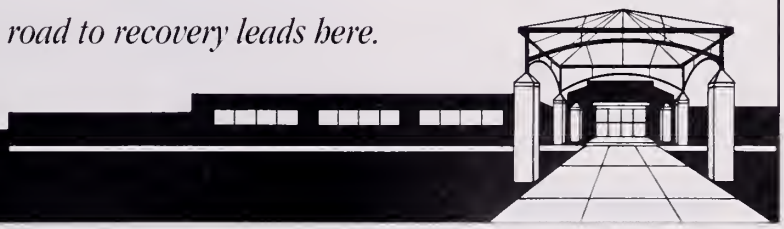

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For more information, call the Storz Cancer Institute at 402-552-6932 or call MD Source toll-free at 1-800-552-5552.

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The Nebraska Medical Journal

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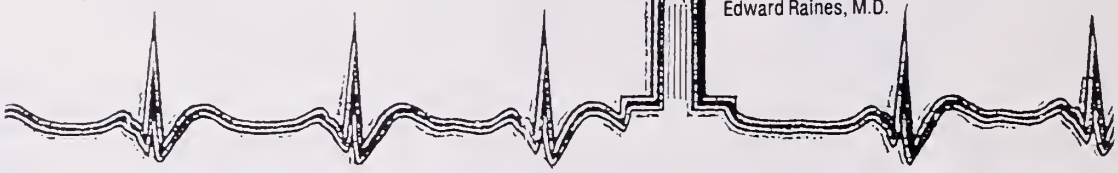

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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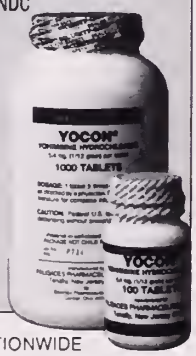

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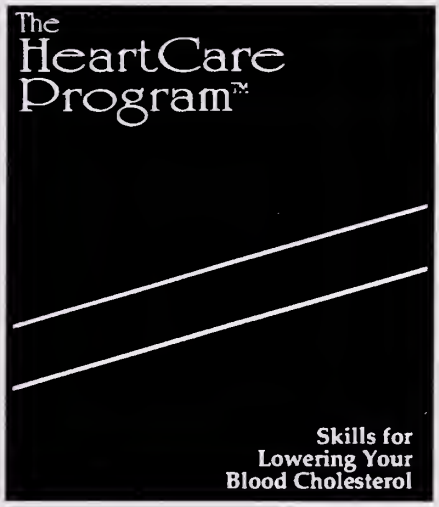

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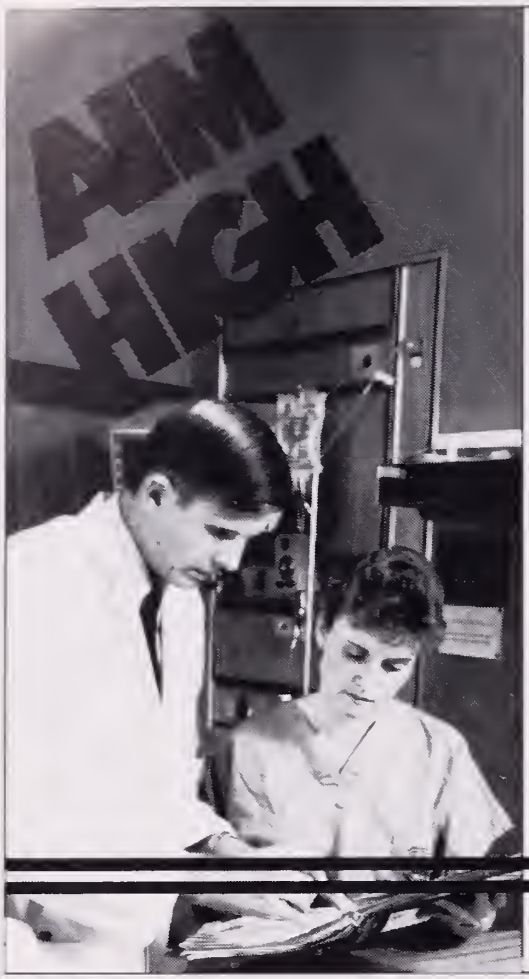

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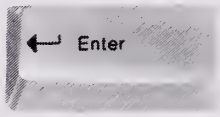

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PRESIDENT'S PAGE

Physicians, Antitrust Laws and Health System Reform

FREDERICK F. PAUSTIAN, M.D.

The Nebraska Medical Association House of Delegates, Spring Meeting 1994, passed resolution #17 directing the NMA Board of Directors to study the value and benefit of establishing a physician directed management service organization and, if deemed feasible, promote the establishment of such an organization.

It was apparent from the beginning that a basic knowledge of federal antitrust laws was necessary so as to avoid violation and the consequences of criminal prosecution, costly civil litigation, and related penalties. Two resource documents proved to be very helpful as regards identification of the laws and understanding them. These are:

1. "Collective Negotiation and Antitrust" published by the Physician Negotiation Advisory Office within the Office of the General Council of the American Medical Association.
2. A letter, concerning antitrust considerations, to the Nebraska Medical Association from Charles M. Pallesen, Jr., an attorney from the office of Cline, Williams, Wright, Johnson, and Oldfather, 11-2-92. [The essence of Pallesen's letter appears in the **Nebraska Medical Journal** Ask A Lawyer column, March 1994.]

Independent physicians and their practices have been placed under considerable pressure by health care insurers and medical delivery system corporations to reduce their fees, grant discounts, and alter their practice characteristics. Because of these pressures and the necessity to have impact, a natural reaction to such forces is to have physicians join together and deal with third party payers collectively. Such collective conduct, however, can result in illegal price fixing, boycott agreements, and other violations of antitrust laws with resultant potential for severe sanctions. Besides criminal prosecution, a losing antitrust defendant in a civil case is liable for three times the amount of any damages the violation caused plus attorney fees for the plaintiff. Antitrust law enforcement is mediated by the United States Department of Justice, the Federal Trade Commission and State Attorneys General. Proceedings may be initiated by any of the foregoing as well as private parties such as competing physicians and third party payers.

Frederick F. Paustian, M.D.

The antitrust law most pertinent to physicians is contained in Section 1 of the Sherman Act. Two elements must be present to establish a violation of the law:

(1.) A concerted action which produces (2.) an unreasonable restraint of competition. A formal written agreement is not necessary to satisfy the concerted action element; all that is required is an informal understanding. Therefore, an association of competing physicians as a medical society could satisfy the concerted action element. Medical societies must be certain that their actions do not unreasonably restrain competition. Physicians must avoid discussing fees or engaging in any group activity which has an impact upon competition. An individual physician, a professional corporation, or an integrated group practice or an IPA may take independent unilateral action as each is considered to be a single entity which, therefore, does not constitute concerted action.

Restraint of competition is measured by two standards. The first is "rule of reason" wherein a court examines all relevant facts and weighs the pro-competitive and anti-competitive effects of the activities. The second type of conduct termed "per se illegal" is always considered to be anti-competitive. Therefore, the courts do not consider evidence about the purpose or effect of such conduct. An example of a per se illegal conduct is a "naked" horizontal price fixing agreement which is an understanding among competitors to raise prices or to charge a particular fee. Another unlawful agreement is a group boycott in which there is an agreement among competitors to refuse to deal with another competitor, supplier, or a customer in order to suppress competition. A physician group boycott occurs when physicians jointly refuse to deal with an HMO or similar plan unless certain contract terms are met. The illegal restraint of competition arises when physicians make decisions as part of a group of otherwise independent competing physicians. Doctors must avoid the use of the threat of a group boycott in negotiations with third party payers. In the setting of peer review action concerning physician credentialing for clinical privileges, it must be certain the reasons for denying desired privileges are based on unsatisfactory credentials or substandard performance and not on restraint of trade.

The antitrust laws do not prohibit any conduct by an individual or medical group, including refusing to participate in a third party payer's program, as long as the conduct represents an individual decision and is not based on any understanding with competing physicians about whether or not to participate. A fully integrated group practice is considered a single entity for antitrust purposes, but also means loss of identity of the individual practice. The antitrust concerns regarding integrated practices relate to:

1. Are they actually integrated?
2. Are they formed for legitimate purposes?
3. Do they include too large a percentage of competing physicians or the physicians of a particular specialty in a given geographic area?
4. Do they prevent the formation and operation of similar entitites?

Some of the criteria which indicate true integration include:

1. Significant capital contribution.
2. Financial risk sharing by the physicians.
3. Establishment of peer review, utilization review, and quality assurance programs by the group.
4. Centralization of business functions.

These indices are also characteristic of a classic management service organization.

The percentage of physicians from a given geographic area participating in an integration is important. If the percentage of physicians involved is less than 20% of the area physicians or a specific specialty there are no antitrust concerns. However, if the percentage of physicians is greater than 35%, there is cause for concern. Furthermore, the participating physicians in a plan should not enter into agreements which prohibit member physicians from participating in other plans.

Medical societies are well positioned to discuss issues with third party payers and government and may represent physicians on economic, education, and ethical concerns. The First Amendment to the United States Constitution protects the right to petition the legislature, courts, and other government agencies, in good faith, for any actions as long as there is no threat the physicians as a group will not participate if their requests are denied. Medical societies may advise physicians on the meaning and consequences of proposals and may retain experts for such purposes as long as the decision whether to accept the particular proposals is left to individual physicians or group practices. The antitrust laws do not prohibit medical societies from expressing the concerns of their members and submitting recommended changes to third party payers provided there is no threat of concerted action. Medical societies may also act on behalf of individual or integrated physicians expressing to payers the views of their members on issues not related to fees as procedures, services, claims processing, utilization and peer review in the absence of any threat of boycott.

Efforts have been made to circumvent antitrust law prohibitions on price fixing through a medical society or association of independent practitioners establishing a "union" which then bargains collectively with third party payers. While there is a "labor exemption" to the antitrust laws, the exemption applies only to collec-

tive bargaining by employees and not to collective bargaining by independently practicing professionals. The same rules apply to a medical society union as to the society itself. It is of paramount importance that medical societies acting in behalf of their members or member groups be assisted by an experienced health antitrust counsel so as to avoid antitrust violation.

Frequent problems confronting medical societies are requests for peer review as to the reasonableness of individual fees and requests for collection of fee information so as to determine average charges for particular services. Such activities are lawful provided the decisions as to what constitutes a reasonable fee or the average charge is not disseminated to the membership. In addition, the information collected and the statistical computations must be conducted by someone other than a competing physician.

Because of the constraints cited above and the fact that health insurance companies are largely exempt from the antitrust restrictions physicians face in establishing and running managed care plans, the AMA is strongly sponsoring the Health Care Antitrust Improvement Act known as the Hatch/Archer bill (S1658/HR3486). The purpose of the act is to "level the playing field" so that physicians, not just insurance companies, can form health care delivery networks and plans. The bill has five specific objectives:

1. Establish a safe harbor under federal antitrust laws which would permit physicians to create joint ventures or take other collective action if they represented fewer than 20% of the physicians in an area.

2. Permit the establishment of networks with as many as 50% of the physicians in a market area provided the participating physicians can and do participate in other plans and are procompetitive.

3. Create a procedure wherein physician networks that do not fall within the safe harbor could notify the Department of Justice (DOJ) about their formation. In return for notifying the DOJ the networks would be subject to "rule of reason" analysis whereby the actual competitive impact of the network on the market is reviewed and determination as to appropriateness or legality is made.

4. Create a procedure for providers to petition the DOJ for additional safe harbors for categories of cooperative arrangements that can be demonstrated to be procompetitive. Such a procedure would be helpful for physicians in small to medium size cities and in rural areas where it might not be possible to organize networks with existing antitrust limits.

5. Recognize the need for physicians to be able to collectively present data and views to insurance plans.

Background information as to the need for antitrust relief is available in AMA publications entitled "Providing Health Care Coverage For All Americans", January 1994; and "Advocacy Initiative-Strengthening Physician Voice Through Health System Reform", June 1994. It is very important for all members of the Nebraska Medical Association to be strongly supportive of the AMA's initiative to obtain antitrust relief so we may continue to be advocates for our patients and maintain control of the quality of health care which is to be delivered to our patients.

The four documents cited above may be requested from the office of the Nebraska Medical Association and must be thoroughly studied in preparation for our consideration of the appropriateness of the establishment of a physician directed management service organization in the State of Nebraska.

Two additional areas are noteworthy.

On September 15, 1993 the Antitrust Division of the U.S. Attorney General's Office (DOJ) and the Federal Trade Commission (FTC) issued a document entitled "Statements of Antitrust Enforcement Policy in the Health Care Area," (available from the NMA). The document contains six policy statements that address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.

The 2 agencies have pledged to issue additional guidelines as needed, and have offered an expedited process of advisory opinions under the existing policy statements. These advisory opinions should bring additional clarity to the policy statements.

In general, the policy statements are helpful because they collect in one place what previously had been widely scattered indications of the enforcement intentions of the DOJ and the FTC. Substantively, however, the policy statements break little new ground. They set forth "safety zones", or safe harbors, describing circumstances under which the agencies will not challenge certain conduct. For the most part, these safety zones are rather limited; they merely describe conduct that has long been considered appropriate under the antitrust laws.

The policy statements also set forth an outline of the analysis the agencies will use to review conduct that falls outside the safety zones. Such conduct is not necessarily illegal, but requires a more detailed analysis than does conduct that falls within the safety zones. This analysis is complicated and its outcome somewhat unpredictable. Therefore, a fair degree of uncertainty about the lawfulness of joint physician conduct remains despite the DOJ/FTC policy statements. Again, physicians should consult competent antitrust counsel before relying on any of these policy statements.

Finally, the 1994 Nebraska Legislature passed LB 1223, which included a section entitled "Healthcare Facility-Provider Cooperation Act." While the regulations have not yet been published, this Act proposes that certain health care providers (hospital, physicians, etc.) that plan to enter into cooperative ventures can choose to voluntarily submit their plans to the Nebraska Department of Health and request a "Certificate of Public Advantage." The Nebraska Attorney General may be consulted by the Department for review and approval. If approved, the law should provide health care provider collaborative efforts some additional protection from later challenges by the federal antitrust authorities.

ORIGINAL ARTICLE

Atheroembolic Renal Disease: Experience With 22 Patients

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ABSTRACT

Atherembolic renal disease (ARD) following an arterographic procedure developed in 17 patients over a 107-month period in which 14,998 procedures were performed at two hospitals. The incidence of ARD per arteriographic procedure was 0.1%. A review of all nephrology consults during this same period identified five patients with ARD unrelated to a procedure (spontaneous disease).

ARD was diagnosed 5.3 ± 0.9 weeks following an arteriographic procedure. Patients most likely to be diagnosed with ARD were those recently undergoing arteriography (77%), the elderly (mean 69.9 years), males (73%), Caucasians (95%) and patients with renal insufficiency prior to arteriography. In the patients who had arteriography, the baseline serum creatinine increased significantly from a mean of 3.0 ± 0.6 mg/dl to 6.6 ± 1.1 mg/dl at the time of diagnosis ($P < .05$). The mortality rate of 16 patients who progressed to end stage renal disease was significantly greater (75%) than 6 patients who recovered renal function (17%; $P < .05$).

ATHEROEMBOLISM is a complication of arteriography with access ususally obtained through the femoral artery.[1] Atheroembolism may also result from surgical manipulation of the aorta.[2] Atheroembolic renal disease (ARD) is caused by atheroembolism to many renal arterioles. ARD may occur spontaneously,[3] particularly in association with renal artery stenosis.[4]

The incidence of atheroembolism following arteriography is difficult to assess because there may be subclinical cases that go undetected. Rosansky[5] reported 9 cases of atheroembolism following 11,402 arteriographic procedures. (.08%). Drost[6] reported 4 cases following 4,487 arteriographic procedures (.09%). The incidence of ARD following arteriography has not been reported previously.

The purpose of this study was to assess the incidence of clinically significant ARD per arteriographic procedure, identify the patient population most likely to be diagnosed with ARD, and to describe the relationship between an arteriographic procedure and renal failure.

Definition

Clinically significant ARD is defined as the presence of acute renal failure combined with clinical and laboratory evidence typical of atheroembolism occurring after arteriography or spontaneously. Clinical manifestations of atheroembolism are covered in detail under "Discussion".

Materials and Methods

Records from the cardiac catheterization laboratories and invasive radiology departments at AMI/St. Joseph Hospital and Archbishop Bergan Mercy Medical Center in Omaha, Nebraska over a 107-month period were reviewed to determine the number of arteriographic procedures performed per year and the incidence of atheroembolic renal disease per procedure. Sufficient data was not available to adequately define the patient population that underwent arteriography. The discharge diagnoses were reviewed from 2,990 consecutive nephrology consultations performed by the Creighton University Nephrology group at the same two hospitals over the same 107-month period. From these reviews, 22 patients were identified with a diagnosis of atheroembolic renal disease; 17 cases following an arteriographic procedure and 5 cases occurring spontaneously. The hospital, outpatient, and dialysis records of these 22 patients were reviewed and data relating specifically to their renal disease was obtained.

Statistical Analysis

The paired two-tailed t-test was used to compare serum creatinines at the times of procedure and diagnosis. Results are presented as ± SEM. Chi-square analysis was used to determine if there was a significant relationship between 1) the need for dialysis at some time during the

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illness and mortality and 2) end stage renal disease (ESRD) and mortality. Statistical significance is reported at the 0.05 level.

Results

Twenty-two patients were diagnosed with atheroembolic renal disease over a 107-month period. Seventeen patients (77%) had ARD related to arteriographic procedures. Ten patients had cardiac catheterizations, four had aortograms with runoffs and three had carotid angiograms. Five patients (23%) had ARD unrelated to a procedure (spontaneous disease). Figure 1 shows the incidence of ARD per year and per procedure per year. Figure 2 shows the number of arteriographic procedures per year at two hospitals. There were 17 cases of procedure-related ARD resulting from 14,998 procedures (0.1%).

Sixteen patients were male (73%). The mean age at the time of diagnosis was 69.9 years. Twenty-one patients were Caucasian (95%). One patient was Hispanic and there were no black patients.

The mean serum creatinine at the time of the procedure in 15 patients were 3.0±0.6 mg/dl. A baseline serum creatinine was not available in the remaining 2 patients who had procedures. Five patients did not have procedures, therefore a baseline creatinine did not exist for them. The mean serum creatinine at the time of diagnosis in all patients was 6.6 ± 1.1 mg/dl. The mean creatinines were significantly different using the paired t-test ($P < .05$).

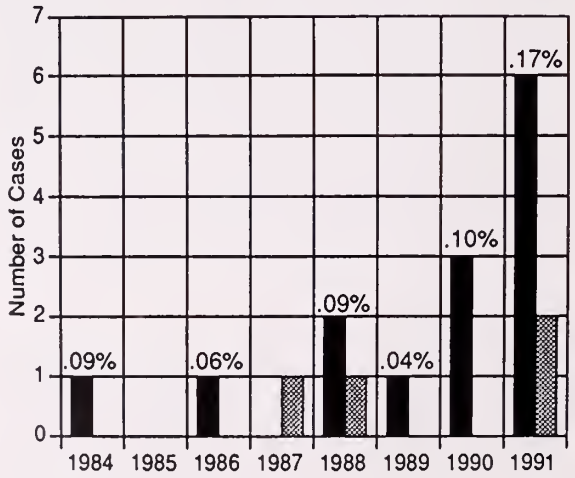

FIGURE 1
Number of cases of ARD diagnosed per year at 2 hospitals. Solid bars represent procedure-related and checkered bars represent spontaneous ARD. Percentages above solid bars equal incidence of ARD per procedure per year. (ARD = Atheroembolic Renal Disease)

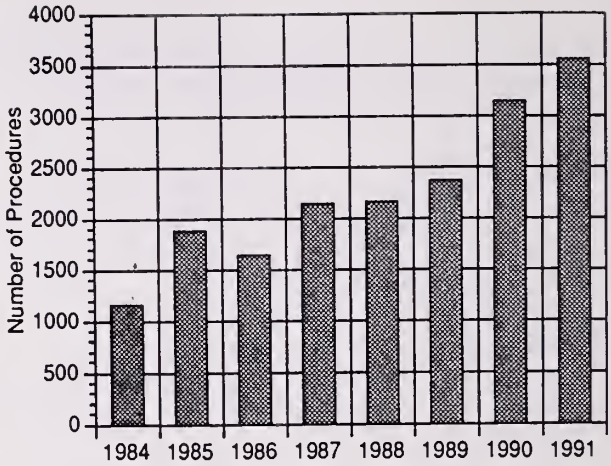

FIGURE 2
Number of arteriographic procedures per year at 2 hospitals.

The mean time ± SEM, range and median for procedure to diagnosis (Dx), Dx to dialysis, total duration of dialysis and survival from the time of procedure to death, are shown in Table 1. One patient survived on dialysis for 364 weeks after her arteriogram, 198 weeks longer than any other patient in the study and was responsible for the large SEMs for duration of dialysis and survival.

Fourteen patients received dialysis therapy at some time during their illness (64%). Seven patients received hemodialysis, 6 patients received peritoneal dialysis, and one patient had both.

The mortality rate of the 14 patients who were dialyzed is compared to that of 8 patients who were never dialyzed in Fig. 3. By use of chi-square analysis, there was no significant relationship between the need for dialysis at some time during the illness and mortality. Also in Fig. 3, the mortality rate of 6 patients who recovered renal function (not ESRD) is compared to that of 16 patients who did not recover renal function (ESRD). By the use of chi-square analysis there was a significant relationship between ESRD and mortality ($P < .05$).

Extra-renal manifestations of atheroembolism were common among the 22 patients with ARD. These included ischemic toes (12 patients), livedo reticularis (7 patients), abdominal pain or ischemia (4 patients), claudication, eosinophilia, accelerated hypertension and transient ischemic attack (2 patients each).

Six patients underwent tissue biopsy for diagnosis. Three patients had calf muscle biopsies,

TABLE 1
Temporal Relationships

	N	Time (wks)± SEM	Range (wks.)	Median (wks.)
Procedure to DX	16	5.3 ± 0.9	.3 - 11.9	5.1
Dx to Dialysis	13	10.3 ± 2.7	.14 - 28	5
Duration Dialysis	14	71.1 ± 25.5	4 - 344	21.5
Survival	9	86.4 ± 39.9	4 - 364	21

SEM = Standard Error of the Mean
wks. = weeks
Dx = diagnosis

only one of which was diagnostic for cholesterol embolism. Two patients underwent renal biopsies, both of which were diagnositc for cholesterol embolism. One patient had a non-diagnostic skin biopsy.

Discussion

Renal involvement with atheroembolism is manifested by the onset of acute renal failure, often following arteriography, associated with clinical findings and laboratory studies typical of atheroembolism. In this study the diagnosis of ARD was made a mean of 5.3 ± 0.9 weeks after the arteriographic procedure (Table 1). Clinical features of atheroembolism include the blue toe syndrome,[7] gangrene[8], ulcers and petechiae of the lower extremities, livedo reticularis of the skin, gastrointestinal bleeding[9], ischemic bowel, pancreatitis, transient ischemic attacks, accelerated hypertension[10], amaurosis fugax, claudication, myalgias, and malnutrition. Characteristic laboratory findings observed with atheroembolism include eosinophilia[11], eosinophiluria, low serum complement levels[12], and elevated erythrocyte sedimentation rate, CPK, transaminases and amylase. The urine may show granular casts, pyuria, hematuria and proteinuria. Extra-renal manifestations of atheroembolism were common in this study consistent with the fact that ARD is part of a multisystem disease with the kidneys rarely being the only organ involved.

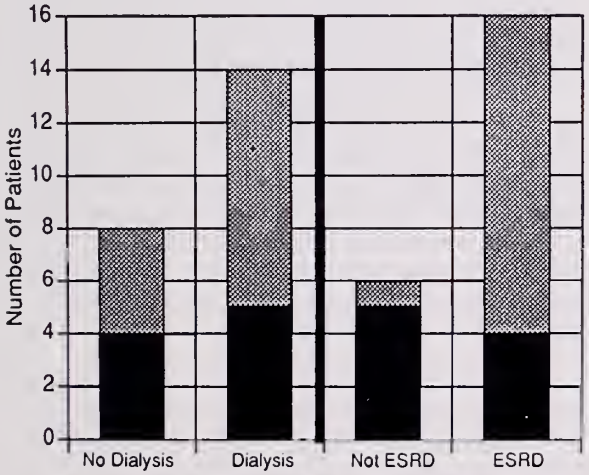

FIGURE 3
Mortality in patients not dialyzed (50%) compared to patients dialyzed (65%; not significant) and mortality in patients who did not progress to ESRD (17%) compared to patients who progressed to ESRD (75%; P < .05). Solid bars represent patients alive and checkered bars represent patients expired at the time of the study. (ESRD = End-stage renal disease)

The pathophysiology of atheroembolism involves the release of cholesterol crystals and other debris from atherosclerotic plaques upon contact with a catheter, or spontaneously. Common sites of origin of atheroemboli are the aorta and femoral and iliac arteries. The atheroemboli then travel downstream to occlude distal arterioles 50 to 100 microns in diameter predominantly in the abdominal viscera, lower extremities, and skin.[14] The eventual result is ischemia and infarction of affected tissue.

Definitive diagnosis can be made by a biopsy of affected tissue, particularly skin or kidney. A blind biopsy of the gastrocnemius muscle[13] may also provide a diagnosis if the lower extremities are involved.

The characteristic histologic finding is the biconvex neddle-shaped clefts that remain in arterioles after dissolution of the cholesterol crystals upon tissue preparation (Fig. 4).[14]

The clefts are surrounded by a foreign body giant cell reaction to the crystal, endothelial and fibroblastic proliferation, and perivascular lymphocytic inflammation.

No specific treatment is available for atheroembolic disease and general supportive measures are indicated such as control of pain and hypertension. Parenteral nutrition may be needed for malnutrition secondary to ischemic bowel. Dialysis may be appropriate for progressive renal failure. Tissue Plasminogen Activator (TPA) has been used successfully for treatment of non-healing ulcers of the lower extremities secondary to livedo reticularis.[15] It remains to be seen if TPA will play a role in the treatment of atheroembolism to visceral organs.

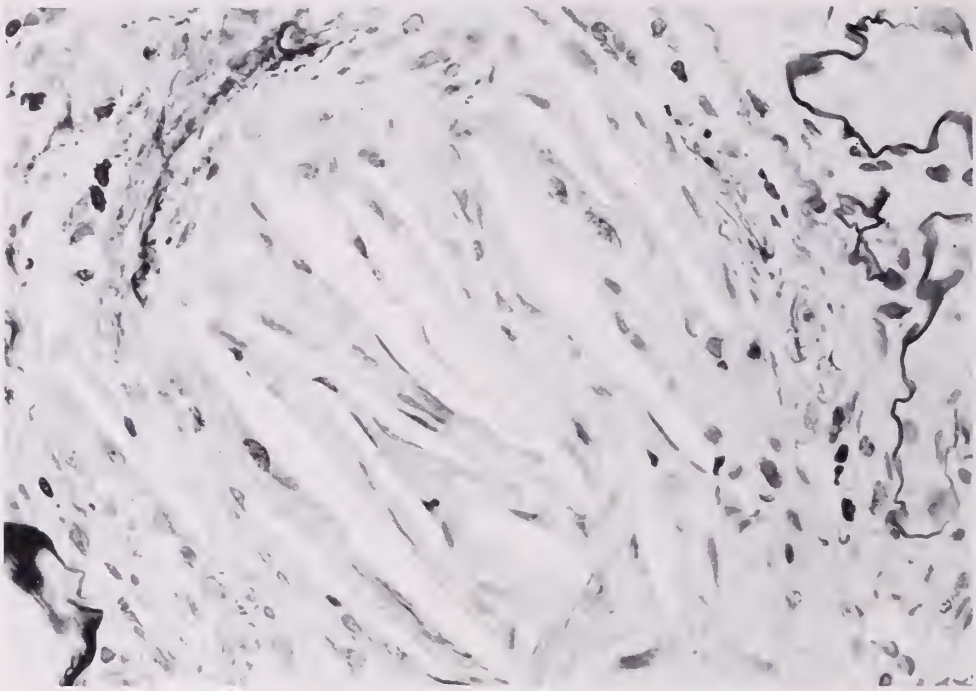

FIGURE 4
Cholesterol clefts in renal arteriole. (hematoxylin-eosin stain, X200)

The patients most likely to be diagnosed with ARD in this study were elderly white males and renal insufficiency prior to arteriography. The paucity of black patients with ARD has been reported previously.[16] An explanation of this observation remains unknown. It is possible that blacks may undergo less arteriographic procedures for socioeconomic reasons.

ARD was fatal in a majority of patients (59%). Mean survival from the time of the procedure was 86.4 ± 39.4 weeks (Table 1). Mortality from ARD was significantly greater if there was progression to ESRD ($P < .05$). Mortality was also greater if dialysis was needed at some time during the illness but this was not statistically significant. These results suggest that mortality was primarily related to permanent loss of renal function (ESRD).

The number of cases of ARD per year increased from 1984 to 1991 because of an increase in the incidence of ARD per procedure (Fig. 1) and an increase in the number to arteriographic procedures performed per year (Fig. 2). It is also possible that more cases of ARD were diagnosed because of increased awareness of the disease. The incidence of ARD per arteriographic procedure from 1984 through 1991 (0.1%) is similar to that reported previously by Rosansky and Drost for the incidence of atheroembolism per procedure (.08-.09%). This suggests that the majority of cases of atheroembolism are associated with ARD.

The incidence of ARD per procedure increased most likely because procedures were performed on patients at increased risk for the disease such as the elderly with advances aortic artherosclerosis. ARD can be prevented by making physicians involved with arteriographic procedures more aware of patients at risk. Patients must be fully evaluated to determine if the risk of arteriography outweighs its benefits.

There are several strategies available to decrease the incidence of ARD in patients at risk. Approach to the arterial system can be made via the brachial artery as opposed to the femoral artery to minimize contact of a catheter with an atherosclerotic abdominal aorta. Studies comparing the incidence of ARD between the two approaches are lacking.

Atherosclerotic debris in the thoracic aorta can be observed during transesophageal echocardiography (TEE).[16] It may be possible to identify patients at risk for atheroembolism by TEE and avoid arterial procedures in them.

Although heparin is commonly used at the time of arteriography and afterwards, it may increase the possibility of atheroembolism in patients at risk.[15] Heparin may prevent the formation of an organized thrombus over an

atheroscelerotic plaque resulting in increased release of embolic debris. More selective use of heparin is indicated in patients at risk.

Atheroembolism with ARD has also been reported following the use of intravenous TPA for acute myocardial infarction.[18] Therefore the risks and benefits of TPA must be weighed in patients at risk for atheroembolism.

In summary, clinically significant ARD was diagnosed approximately five weeks following an arteriographic procedure. Elderly white males with prior renal insufficiency were diagnosed most frequently. Twenty-three percent of patients had spontaneous disease. Progression to ESRD was a predictor of mortality. The incidence of ARD per arteriographic procedure was 0.1%.

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ORIGINAL ARTICLE

Intraventricular Hemorrhage in the Premature Infant

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INTRODUCTION

DESPITE years of steady improvement in the treatment of premature babies, 10 to 20% of NICU survivors will have long-term neurodevelopmental handicaps.[1] This likely reflects not a lack of progress, but rather, a trend in keeping ever smaller and younger "premees" alive. One of the most common causes of long-term neurologic sequelae in the population is germinal matrix hemorrhage (GMH), also known as subependymal hemorrhage and the related condition of intraventricular hemorrhage (IVH), which can lead to post-hemorrhagic hydrocephalus (PHH). While 80% of cases of IVH detected by routine ultrasonography will have a benign course, the potential for significant morbidity and mortality necessitates early detection and, when indicated, aggressive treatment.[2]

INCIDENCE

The incidence of IVH/GMH is in no small part dependent upon the means of detection employed; however, realistic estimates are 40 to 45% of infants with birth weights < 1500 grams and/or gestational ages < 35 weeks.[3] IVH is most commonly seen in infants of < 32 weeks gestational age, although it has been reported in term infants.[4] Fifty percent of infants with IVH/GMH will develop the hemorrhage (as detected by transfontanelle ultrasound) in the first post-natal day while 90% of bleeds occur within the first 72 hours.[5] Progression of GMH to IVH of worsening grade is seen in 10 to 20% of cases, with those children having the youngest gestational age being most likely to progress.[6] While PHH can be acute in presentation, it is more typically manifested one to three weeks after the initial detection of IVH.[7] The incidence of PHH is estimated to be between 25 and 74% of infants with IVH.[8]

Papille, et al, developed a grading scheme for GMH/IVH which can be applied to CT or ultrasound appearance and allows for prognostication and treatment decisions.[3] Grade I is a pure germinal matrix hemorrhage or subependymal hemorrhage. Grade II is GMH with associated intraventricular hemorrhage but no ventriculomegaly. Grade III is IVH accompanied by ventriculomegaly (distention of one or more of the cerebral ventricles). Grade IV is IVH with ventriculomegaly and parenchymal extension of blood beyond the limits of the germinal matrix.

The etiology of IVH has been extensively studied. While IVH was once considered essentially an obstetrical complication, Horbar, et al, showed by means of extensive statistical analysis that there was no association between any single obstetric factor and the occurrence of IVH (utilizing multivariate analysis).[9] A univarite association was demonstrated between gestational age and prolonged labor with IVH (inverse). It is now recognized that alteration in cerebral flow (CBF) is the most likely major etiologic factor. The germinal matrix is a residuum of the embryonal brain tissue which contains a rich capillary bed that typically involutes around gestational week 32-34. These vessels are believed to be "immature" in the sense of being both mechanically fragile and lacking autoregulation of flow.[10,11] As such, events producing an increase in CBF can cause a disproportionate flow of blood through this tissue which lies beneath the ependyma of the lateral ventricles in the premature infant. The most frequently implicated condition in producing IVH is hypoxia and associated hypercapnia leading to increases in both cerebral perfusion pressure and CBF.[12] Other risk factors include: volume expansion following hemorrhagic hypotension, seizures (CBF has been shown to increase in convulsing infants prior to the development of GMH), pneumothorax, hypertension, cyanotic heart disease (including patent ductus arteriosis), and mechanical ventilation especially in the setting of respiratory distress syndrome.[13]

The development of post-hemorrhagic hydrocephalus is felt to be secondary to an obliterative arachnoiditis in which RBC's and

the breakdown products of the extravasated blood block the pathway for cerebrospinal fluid (CSF) absorption.[7] This accounts for the previously mentioned delay often seen between diagnosis of IVH and onset of symptomatic PHH. With more severe Grade III and IV bleeds, it is possible to have an acute presentation of noncommunicating hydrocephalus secondary to clot blocking flow of CSF at the level of the cerebral aqueduct.

TREATMENT

The treatment goal in the setting of IVH is first to optimize cerebral perfusion pressure to prevent worsening of the hemorrhage. Second is the control of ventriculomegaly thereby preventing the cascade of neuronal injury which can be produced either from mechanical distortion of normal brain by the enlarging ventricles or from increasing intracerebral pressure in the setting of hydrocephalus. The effectiveness of currently available treatment is dependent upon early diagnosis and prompt initiation of appropriate measures. The frequent use of cerebral ultrasonography in the NICU setting allows for early diagnosis of IVH, including the significant number of Grade I and Grade II hemorrhages which will often amount to essentially incidental findings. However, since not all IVH's will be apparent on early sonograms, an index of suspicion based upon clinical findings and risk factors may necessitate repeat sonograms and/or CT scanning. The clinical presentation of IVH may be acute or subacute. A rapidly expanding head circumference with bulging fontanelle may be seen, or the more subtle picture of head circumference accelerating on the growth chart faster than body weight in the setting of the "full but soft fontanelle". Poor feeding and irritability are frequent findings. Vomiting, lethargy, and changes in muscle tone (up to and including flaccidity) may also be seen. Cardiorespiratory disturbances are common; presenting as apnea and/or bradycardia (A's and B's). An otherwise unexplained decrease in hematocrit of > 10% may also be an early presentation, especially in the setting of a GMH that progresses to IVH of higher grade.

Despite the benign nature of most Grade I and II IVH's, 80% of Grade III and Grade IV IVH's will require active intervention and 60 to 75% of these infants will need permanent CSF diversion by ventriculoperitoneal shunting.[14] The first step in treating all IVH's is to normalize mean arterial pressure and pCO2. This, in conjunction with treating any associated medical problems in a given infant, serve to lessen the risk of hemorrhage progression by optimizing cerebral perfusion pressure. This is typically the only treatment (other than close observation) required for infants with Grade I and II IVH. A mild ventricular enlargement may occur due to a self-limiting communicating hydrocephalus, but if no other systemic insults arise, these children can be expected to have a normal neurodevelopmental outcome.

For those infants with Grade III/IV IVH, a regimen of medical treatment is initiated with surgery reserved as a last course which, in the case of permanent VP shunts, must often be used only after a delay to allow the child to grow and the CSF to clear.

Medical treatment consists of a combination of Diamox, Lasix, and Polycitrate (DLP). The use of Diamox and Lasix has been shown to decrease CSF production by as much as 50%.[15] In many children without signs of elevated ICP, this measure will be definitive. Likewise, the slowing of CSF production by this treatment is advantageous in these children who will require VP shunting but who at time of diagnosis are too small to be shunted. The major argument against Diamox and Lasix treatment has been the production of metabolic acidosis in the infant. The use of Polycitrate (available both in Na+ and K forms) obviates this problem although daily monitoring of electrolytes and acid/base balance is required. Diamox can cause diarrhea, but this is prevented by giving it in IV form or in eight divided doses daily with feedings (see doses below). The only strict contraindication to DLP therapy is severe bronchopulmonary dysplasia and/or pneumonia. While Polycitrate or alternatively IV sodium bicarbonate allows for an acceptable acid/base balance, these children still tend to develop a compensatory increase in respiratory rate which may be beyond the reserves of an infant already faced with an oxygenation problem. DLP therapy requires a trial of 5 to 7 days to adequately assess its effectiveness. Lasix is given 1 mg/kg/day p.o. divided t.i.d. or 0.5 mg/kg/day divided t.i.d. if given IV. Polycitrate is given 3 to 5 mEq/kg/day p.o. divided t.i.d., with dose adjusted as needed. Sodium bicarbonate 2 mEq/kg/day IV can be given as an alternative or adjunct. Diamox is initiated at 25 mg/kg/day on day one, then 50 mg/kg/day on day two, then 100 mg/kg/day on day three and thereafter, with the dose divided t.i.d. for IV administration or in up to 8 daily doses if given with gavage feedings. Those infants responding to DLP treatment alone are "weaned" off the drugs over three months by

maintaining total dose at the amount given at time of discharge from the hospital.

Lumbar puncture can be performed during the time DLP is first initiated. While CSF drainage in this fashion can decrease the negative effect of ventriculomegaly, it is a purely temporizing measure, and in those children with noncommunicating hydrocephalus (from clot) it is likely of little effect.[16]

For children with severe Grade III/IV IVH or progressive PHH or those with symptoms of elevated ICP (such as A's and B's), early transfontanelle ventricular tap may be helpful. Bilateral simultaneous taps using 20 gauge angiocaths and withdrawal of 10 to 15 ccs from each side is done preferably on the day of hemorrhage. The use of closed system ventricular lavage with sterile saline at the time of the initial tap not only lowers ICP but facilitates removal of significant amounts of clot potentially decreasing the factors leading to progressive or persistent hydrocephalus. It is not unusual to see a significant improvement in the infants oxygen saturation following this procedure which may reflect a component of neurogenic pulmonary dysfunction in those infants with elevated ICP. While serial ventricular taps in this fashion would seem efficacious, experience has shown that repeated transfontanelle taps result in the development of frontal porencephalic cysts. This most likely is secondary to disruption of the ependyma allowing CSF under pressure to pass up into the needle tract through the brain. An alternative to multiple ventricular taps is surgically placing a ventricular catheter connected to a subcutaneous reservoir under the scalp. This system can then be percutaneoulsy accessed (up to three times a day) to drain CSF as needed to keep ICP down. Due to problems with infection and wound breakdown even over the small pediatric reservoir, this procedure is not recommended for infants weighing less than 1100 grams. Occasionally an infant may require two or three ventricular taps and/or serial LP's until the child is large enough to undergo reservoir placement. In a small number of children, the need for serial CSF removal will decrease, especially in those who are concurrently receiving DLP treatment, and the subcutaneous reservoir can be removed. In those who continue to need CSF drainage the reservoir can be replaced with a VP shunt. Each time CSF is obtained (whether by LP, transfontanelle tap or access of subcutaneous reservoir), it should be sent for cell count, gram stain, culture and sensitivity, and protein level. Ideally, CSF protein should be less than 100 mg/dl prior to attempting permanent VP shunting as high protein concentration and/or cellular debris lead to unacceptably high rates of shunt malfunction necessitating reoperation. Likewise, placement of VP shunts in infants less than 2500 grams results in extremely high infection rates, with multiple obstructions and reoperations. Multivariate analysis by Boynton et al has shown that the number of shunt revisions inversely correlates with survival.[17] It therefore seems prudent to delay shunting in selected cases until the likelihood of a single shunt remaining functional is maximized.

Outcomes for infants with severe IVH include a 20% mortality rate from causes unrelated to the IVH. For infants with Grade III IVH, a 40% incidence of neurodevelopmental deficit can be expected which increases to a 65% incidence of handicaps in those with Grade IV.[18] Approximately 75% of this group will require a permanent VP shunt.

SUMMARY

In summary, IVH is a frequent occurrence in premature infants and will continue to be seen in practice so long as neonatologists remain successful in keeping these very small babies alive. While the low-grade IVH's are typically self-limiting conditions, more profound hemorrhages can have devastating effects on the neonate and initiate a progressive chain of events leading to significant neurodevelopmental morbidity. Early diagnosis and prompt medical management can allow a significant number of children to avoid permanent ventriculoperitoneal shunting. While a large number of these children will require a VP shunt, careful optimization of the child's condition prior to shunting in conjunction with a meticulous surgical technique designed to decrease infection rate allows many of these children to lead essentially normal lives. A team approach involving obstetrical care directed towards prevention of early labor and avoidance of hypoxia and hypercapnia at delivery combined with aggressive management by the neonatologist and early neurosurgical consultation is leading to a more hopeful future for many of these infants.

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PERINATAL PAGE

Volvulus, The Deadly Twist

L.R. SCHULTZ, M.D.

MIDGUT volvulus with gangrene resulting from malrotation is devastating occurrence in the neonate. About 40% of the children who develop symptoms from malrotation have symptoms within the first 10 days of life. Volvulus may also occur in utero producing variable degrees of ischemic necrosis. This may result in atresia of the jejunum or ileum with loss of bowel to produce short gut syndrome.

An abnormal position of bowel caused by an arrest in the embryologic development has been broadly defined as malrotation. Because of the arrest in rotation, there is partial or complete absence of fixation of the midgut. This then allows the bowel to twist around its blood supply. This twist around the superior mesenteric artery and vein is called a volvulus. If the volvulus becomes tight enough, congestion of the mesenteric blood supply occurs. Ischemia and necrosis of part or all of the small bowel may then occur. Usmani has reported two cases of intra-uterine volvulus which caused extensive bowel necrosis that were not associated with malrotation.

The initial symptom of a volvulus is usually greenish bile stained vomiting or greenish like stained gastric aspirate. There is usually a rapid progression of symptoms from the associated ischemia of the midgut. Shock, bloody diarrhea and a tense distended abdomen are ominous signs of intestinal gangrene. It is critical that the primary care physician be alert to the importance of these symptoms so that early diagnosis and expedient surgical correction can be accomplished.

The first diagnostic study usually performed is the plain film of the abdomen. A volvulus can be suspected if the duodenum is dilated. However, complete obstruction is rare and air is usually seen distally in the small bowel. The barium enema diagnosis is based on an abnormal position of the cecum. However, a mobile cecum can make a definitive diagnosis impossible. A subsequent upper GI series is then required if there is a high index of suspicion that a volvulus and obstruction exist. An abnormal position of the duodenum and the lack of a normally located ligament of Treitz will confirm the diagnosis. Ultrasound of the abdomen has been used by some to show the abnormal orientation of the mesenteric vessels. In these acutely obstructed infants who are obviously ill, special diagnostic procedures should be avoided and early operative intervention accomplished.

The morbidity and mortality is significant in babies with volvulus and intestinal necrosis. Long term morbidity from short gut syndrome is a certain complication if it is necessary to remove a long segment of necrotic small bowel.

Advances in neonatal surgery and perioperative care, most notably parental nutrition, have greatly reduced the morbidity and mortality of this condition. Bile emesis or bile stained gastric aspirate in the newborn should alert the primary care physician that a bowel obstruction may be present and prompt diagnostic and surgical correction is imperative. Additional improvement would be possible if very early diagnosis and treatment can be accomplished.

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FRACTURE OF THE MONTH

Arthroscopic Ankle Fusions Utilizing Bone Marrow and Demineralized Bone Matrix: A Case Report

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INTRODUCTION

Since Albert's first description of ankle arthrodesis in 1879 more than 30 different surgical techniques have been introduced. Complication rates have been reported to be as high as 60% with an infection rate of 10-15%. Recently there have been reports of the utilization of a new technique of ankle fusion utilizing the arthroscope for debridement. We report a case of an ankle fusion utilizing the arthroscopic technique with bone marrow and demineralized bone matrix injected after the joint debridement to stimulate fusion of the ankle.

CASE REPORT

A 60-year-old male presented with a painful ankle during activities of daily living. The patient had sustained an ankle fracture in 1967 which was treated with closed reduction and casting. He experienced progressive increase in pain with radiographic evidence of joint degeneration. His physical exam revealed only ten degrees of plantar flexion and dorsiflexion. His subtalar motion was preserved and felt to be nonpainful on clinical examination. Radiographs at the time of presentation revealed loss of normal ankle joint space with associated anterior osteophyte formation (Figures 1a and 1b).

He underwent an arthroscopic ankle fusion utilizing an AO distractor to facilitate debridement of the degenerative cartilage. Bone marrow was aspirated from the iliac crest in a technique that was first described by Connolly.[1,2] The bone marrow was then mixed with demineralized bone matrix that was obtained from the Red Cross Bone Bank. The bone marrow and demineralized bone matrix was injected through the arthroscopic portals into the debrided and distracted ankle joint. The AO fixator was reversed and used as a compressor to eliminate the debrided ankle joint. Three cancellous screws were percutaneously placed to maintain stabilization, and fusion was radiographically confirmed at six weeks and physical examination revealed no instability or discomfort. Follow-up films were obtained 46 months postoperatively confirming an excellent radiographic fusion (Figures 2a and 2b). Clinically the patient has no pain and is without complaints at this time.

DISCUSSION

The number of different surgical procedures that have been introduced reflect the difficulty in finding a single method in achieving ankle arthrodesis with consistent good results. There have been many open methods reported using anterior sliding grafts, compression arthrodesis using external fixation, and crossed screw fixation. The most commonly used methods today utilize either internal fixation or external fixation. Complication rates with either method have ranged from 28% to 60%. The first report of arthroscopic ankle fusion appeared by Myerson (1989).[3] He described the technique utilizing an external fixator for distraction and debridement of the degenerative cartilage. He then percutaneously placed cancellous screws for compression across the joint. Subsequently, Myerson and Quill (1991) have presented a series of 17 cases done with this technique.[4] Fusion rate was high with only one pseudoarthrosis. There was one malunion where the joint was placed in 20 degrees of equinus. The mean time to arthrodesis was 8.7 weeks compared to 14.5 weeks with those that underwent an open procedure.

Two additional studies have been published using an arthroscopic method. Ogilvie-Harris et al (1993) published their series of 19 patients who had osteoarthritis.[5] They had a 10.5% nonunion rate with no infections. Dent et al (1993) reported a small series of eight patient.[6] All went on to clinical union. Half demonstrated radiographic union. Fifty percent underwent

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FIGURE 1A **FIGURE 1B**

AP and lateral radiographs of the ankle joint revealing degenerative arthritis of the tibiotalar joint.

FIGURE 2A **FIGURE 2B**

AP and lateral radiographs revealing solid tibiotalar arthrodesis.

subsequent removal of the hardware. They had no infections in their group. Connolly (1989) developed a technique of grafting nonunions of the tibia with bone marrow that was aspirated from the iliac crest.[1] His early results (1989) were extremely encouraging with experimental studies being done to confirm the production of bone from aspirates from the iliac crest. The combination of bone marrow and demineralized bone matrix to fill larger defects has been shown to be effective by Tiedeman, Connolly, Strates, and Lippiello (1991).[7]

It is felt the combination of the demineralized bone matrix and bone marrow grafting technique combined with arthroscopic debridement of the ankle joint may further increase the rate of fusion. Reported here is the first case that was performed which went on to an excellent clinical and radiographic result.

We have presently performed 41 arthroscopic ankle arthrodesis procedures utilizing this technique. At an average two year follow-up, there have been only three clinical nonunions.

The advantages of the arthroscopic procedure is that the patient is more comfortable postoperatively which lessens the hospital stay. In addition, the malleoli are preserved providing stability to the ankle fusion. The patient is able to wear normal footwear and there is minimal loss of height.

We recommend this procedure as an alternate method of providing surgical fusion for painful tibiotalar joint arthritis with minimal deformity.

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ASK A LAWYER

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1. What are the requirements of a physician with respect to completion of birth certificates?

A. The sex and date of birth of all children born in the hospital during the preceding month must be reported to the Department of Health the first day of each month along with the names and addresses of the parents and attending physician. Neb. Rev. Stat. § 71-610 (Reissue 1990); 175 NAC 9-003.04D1.

B. A birth certificate for each birth or stillbirth must be filled out by the physician in attendance. If there is no physician in attendance at the time of birth, then the parent or other person present must file a birth certificate with the local registrar within five (5) days of the birth. Neb. Rev. Stat. § 71-604 (Reissue 1990); 175 NAC 9-003.04D1. See "Certificate of Live Birth Instructions" from the Nebraska Bureau of Vital Statistics.

C. The birth certificate above must indicate whether or not a blood test for syphilis was made on the woman who bore the child. Neb. Rev. Stat. § 71-502.03 (Reissue 1990).

2. What must a physician do concerning completion of death certificates and disposal of the remains?

A. The physician has the responsibility and duty to complete and sign in his or her own handwriting, within twenty-four hours from the time of death, that part of the certificate of death entitled medical certificate of death. In the case of a death when no person licensed as a physician was in attendance, the funeral director refers the case to the county attorney for a death certificate.

No cause of death shall be certified in the case of the sudden and unexpected death of a child between the ages of one week and three years unless an autopsy is performed at county expense by a qualified pathologist, unless the parents or guardian signs a written waiver of the right to autopsy. The parents or guardian shall be notified of the results of the autopsy by their physician, community health official, or county coroner within forty-eight hours. The term sudden infant death syndrome shall be entered on the death certificate as the principal cause of deaths when the term is appropriate descriptive of the pathology findings and circumstances surrounding the death of a child.

If the circumstances show it possible that death was caused by neglect, violence or any unlawful means, the case shall be referred to the county attorney for investigation and certification. The county attorney shall, within twenty-four hours after charge of the case, state the cause of death as ascertained, giving as far as possible the means or instrument which produced the death. All death certificates shall show clearly the cause, disease, or sequence of causes ending in death. If the cause of death cannot be determined within the period of time stated above, the death certificate shall be filed to establish the fact of death. As soon as possible thereafter, and not more than six weeks later, supplemental information as to the cause, disease, or sequence of causes ending in death shall be filed with the Department to complete the record. For all certificates stated in terms that are indefinite, insufficient, or unsatisfactory for classification, inquiry shall be made to the person completing the certificate to secure the necessary information to correct or complete the record.

A completed death certificate shall be filed with the Bureau of Vital Statistics within five business days after the date of death. If it is impossible to complete the certificate of death within five business days, the funeral director shall notify the bureau of the reason for the delay and file the certificate of death as soon as possible.

B. No dead human body shall be removed from the State for final disposition without a transit permit issued by the funeral director having charge of the body in Nebraska, except that when the death is subject to investigation, the transit permit shall not be issued by the funeral director without authorization of the

county attorney of the county in which the death occurred. No agent of any transportation company shall allow the shipment of any body without the properly completed transit permit prepared in duplicate.

C. A child born dead shall be registered as a fetal death on a certificate form furnished by the Department of Health. Such certificate shall not be required for a child which has not advanced to the twentieth week of gestation. The certificate shall be filed with the Bureau of Vital Statistics by the funeral director in charge of the funeral and shall include a statement of cause of death made by a person holding a valid license as a physician who was in attendance. In the event of hospital disposition, as provided in section 71-605, the entire certificate shall be completed by the attending physician and subscribed to also by the hospital administrator or his or her designated representative. If the attendant is not a physician, the death shall be referred to the county attorney for certification. The same time limit for completion shall apply as for a regular death certificate. Neb. Rev. Stat. § 71-606 (Reissue 1990).

The death certificate should be signed by the doctor in attendance at the time of death. If a doctor is not in attendance or circumstances show that it is possible that death was caused by neglect, violence or any unlawful means, the County Attorney should be notified. Neb. Rev. Stat. § 71-605 (Reissue 1990). He is ex officio the County Coroner in Nebraska. Neb. Rev. Stat. § 23-1210 (Reissue 1987). The coroner's physician who is appointed by the Coroner must certify to the cause of death in every case of death in the county which is not certified by an attending physician. Neb. Rev. Stat. § 23-1820 (Reissue 1987). If there is no Coroner or if the Coroner is absent or unable to act, the Sheriff of the county is authorized to discharge the duties of the Coroner in relation to dead bodies. Neb. Rev. Stat. § 23-1817 (Reissue 1987).

D. A person claiming to be related by blood or marriage to the deceased has the right to control the disposition of the remains of a deceased person, providing he assumes all financial obligation relative to disposition of such body. Unless other instructions have been given by the decendent, the right vests in the following order: spouse, adult child of decendent, surviving parent, adult brother or sister of decedent, an adult person in the next degrees of kindred. Neb. Rev. Stat. § 71-1339 (Reissue 1990): and Neb. Rev. Stat. § 30-2303 (Reissue 1989).

If not claimed in ten (10) days as described above and the deceased was not honorably discharged from the military or naval service of the United States, the Chairman of the State Anatomical Board should be notified. Neb. Rev. Stat. § 71-1002 (Reissue 1990). The State Anatomical Board or its duly authorized officers or agents, shall have the power to make an examination of any such dead body as may be necessary, and certify as to the cause of death. Neb. Rev. Stat. § 71-1005 (Reissue 1990).

No such body shall be delivered to the board, if any person shall claim the body for burial within ten days after death nor shall any body be delivered to the board if the deceased was honorably discharged from the military or naval services of the United States. Neb. Rev. Stat. § 17-1002 (Reissue 1990)

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"Ask a Lawyer" is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the **Nebraska Medical Journal**. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

IN MEMORIAM

By medicine life may be prolong'd
yet death
Will seize the doctor too.

- Shakespeare

GUILLERMO O. AUSTRIA, M.D. • (Born December 13, 1908 - died May 3, 1994). Medical Specialty - General Practice. Doctor Austria was a graduate of the Creighton University School of Medicine in 1952. He was a member of the Nebraska Medical Association and the American Medical Asociation. He is survived by his wife, Rose; son, Robert, and three grandsons, all of Council Bluffs; brothers, Gabriel of the Phillipines, Ruffy of Honolulu, and Chris of Sacramento, CA.

ROBERT B. BENTHACK, M.D. • (Born May 24, 1924 - died March 25, 1994). Medical Specialty - Family Practice. Doctor Benthack was a graduate of the University of Nebraska College of Medicine in 1947 and practiced in Wayne. He was a member of the Nebraska Medical Association and the American Medical Association. He is survived by his wife, Mary; his parents, Dr. Walter & Phebe Benthack of Wayne; four sisters and three brothers-in-law; nieces and nephews.

CHARLES M. BRESSMAN, M.D. • (Born July 16, 1930 - died March 2, 1994). Medical Specialty - General Practice. Doctor Bressman was a graduate of the University of Nebraska College of Medicine in 1955. He was a member of the Nebraska Medical Association and the American Medical Association. He is survived by his wife, Jean D.; sons and daughters-in-law, Charles M., Jr. and Patricia A. Bressman, Omaha; E. David and Jennifer L. Bressman, Bennington, NE; daughters and sons-in-law, Carol J. and Matthew Smolsky, Des Moines, IA; Sarah D. and David L. Lemon, Omaha; five grandchildren and one sister, Donna A. Beckner of Arlington, VA.

RICHARD E. GARLINGHOUSE, M.D. • (Born March 5, 1910 - died November 17, 1993). Medical Specialty - Obstetrics and Gynecology. Doctor Garlinghouse was a graduate of the University of Pennsylvania School of Medicine, Philadelphia, in 1934. He was a member of the Nebraka Medical Association and the American Medical Association. Doctor Garlinghouse served as President of the Nebraska Medical Association from 1964 - 1965. Survivors include his wife, Miriam; a son, Richard, of San Francisco; and a daughter, Gretchen Huddleston, of Oakland, CA.

LAWRENCE J. GRIDLEY, M.D. • (Born February 25, 1914 - died October 19, 1993). Medical Specialty - Ophthalmology. Doctor Gridley was a graduate of the University of Nebraska School of Medicine in 1941. He was a member of the Nebraska Medical Association and the American Medical Association. Survivors include his daughter, Halcyon Yorks of Loveland, CO; son, Robert L. Gridley of Scottsbluff; sister, Jean Glover of Ft. Collins, CO; and one grandchild.

MURRAY F. MINTHORN, M.D. • (Born August 8, 1922 - died March 24, 1994). Medical Specialty - General Practice. Doctor Minthorn was a graduate of the University of Nebraska College of Medicine in 1948. He was a member of the Nebraska Medical Association and the American Medical Association. He is survived by his wife, Georgialee; sons, Larry, Iowa City, IA, Tom, Seattle; daughter, Patty McConnell, Seattle; one brother, Dr. Martin L., of Gaithersburg, Maryland; and seven grandchildren.

CHARLES H. NEWELL, M.D. • (Born March 5, 1927 - died March 22, 1994). Medical Specialty - Radiology. Doctor Newell was a graduate of the University of Nebraska College of Medicine in 1955. Doctor Newell was a member of the Nebraska Medical Association and became a life member in the state association in 1989.

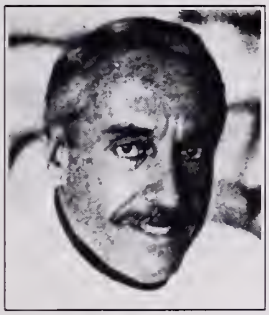
JAMES E. RAMSAY, M.D. • (Born May 25, 1920 - died March 5, 1994). Medical Specialty - Family Practice. Doctor Ramsay graduated from the University of Nebraska Medical School in 1946. He was a member of the Nebraska Medical Association and the American Medical Association. Doctor Ramsay is

survived by one son, John of Albia, IA; one daughter, Cindy Ramsay of Kansas City, MO; two sisters, Frances L. Ramsay and Helen T. Ramsay, both of Denver; and six nieces and nephews.

JOSE A. SAPORTA, M.D. • (Born November 14, 1923 - died April 3, 1994). Medical Specialty - General Surgery. Doctor Saporta was a 1953 graduate of Argentina Facultad de Ciencias Medicina de la Universidad de Buenos Aires, Buenos Aires. He was a member of the Nebraska Medical Association and became a life member of the NMA in 1992. Survivors include his wife, Gertrude; daughter and son-in-law, Virginia and Dr. Murry Brown, Atlanta, GA; sons and daughter-in laws, Drs. Jose A. (Saporta), Jr. and Ann Ling Li, of Boston, MA; Laurence (Leo) Saporta, Omaha; one sister, Matilda Saporta, San Francisco, CA; and four grandchildren.

ROBERT D. SIDNER, M.D. • (Born November 15, 1939 - died March 16, 1994). Medical Specialty - Internal Medicine. Doctor Sidner was a graduate of the University of Nebraska college of Medicine in 1964. Doctor Sidner was a member of the Nebraska Medical Association and the American Medical Association. He is survived by his wife, Teresa; sons, Samuel, Lincoln; Daniel, Val d'Isere, France; daughers, Jennifer, Elm Creek; Susan, Boston; mother, Mrs. S.S. Sidner, Kearney; and a brother, Stephen, Scottsdale, AZ.

COVER PHOTO BIOGRAPHY



GENE RONCKA

Gene Roncka was introduced to art early by a father who was a graphic printer. After military service, he attended the University of Nebraska, then the Art Center in Los Angeles. Graduating with honors, he worked in New York City and furthered his studies with some of the finest talent in the field of art. He moved to Detroit and completed his post graduate education at Cranbrook Academy of Art.

The Roncka style has definitely caught the eye of the public. Gene has received special recognition from Time Magazine and General Motors. He also was selected for the First of State Nebraska Habitat Stamp Competition, was commissioned for animal paintings for the documentary "Wild Kingdom", was finalist for National Ducks Unlimited "Artist of the Year", Best of Show Kansas and Oklahoma Ducks Unlimited. He was the 1992 Nebraska Ducks Unlimited "Artist of the Year" and has been selected as "Artist of the Year" in 1994 for "Wings Over the Platte". He has also been featured in several national magazines, including "Nebraskaland" and "In Fisherman".

Gene has his own distinctive style, with subtletry being an important aspect. Soft muted color and ethereal quality of his works seem to epitomize what is best in his richly painted canvases. He paints more than most see, he includes the very "feelings" which make emotion an outstanding part of his paintings.

Gene has described his works as "Capturing a moment in time that all of us have experienced, either in fact or fiction".

In 1985 Gene and his brother Richard, formed their own art publishing company, Willow Point Limited, in Ashland Nebraska, which has established a network of art galleries nationwide.

COMING MEETINGS

CREIGHTON UNIVERSITY

SEPTEMBER 17, 1994 • Patient Education Strategies for the Primary Care Physician and their Support Staff (Department of Family Practice) - Henry Doorly Zoo, Omaha, NE.

SEPTEMBER, 18-24, 1994 — Anesthesiology Review Course - Professional Seminars - Boston, MA.

SEPTEMBER 29, 1994 — Update in Obstetric Ultrasonography, Marriott Hotel, Omaha, NE.

SEPTEMBER 30 - OCTOBER 1, 1994 — Day With the Perinatologists - Marriott Hotel, Omaha, NE.

OCTOBER 4, 1994 — T.T. Smith Lecture - Boys Town National Research Hospital Auditorium.

OCTOBER 7, 1994 — Fifth Annual: Come Home to Creighton, Skutt Student Center, Creighton University, Omaha, NE.

OCTOBER 8, 1994 — Cardiology Program - Henry Doorly Zoo.

OCTOBER 15, 1994 — Residents Teaching Skills Program, Criss Building, Creighton University, Omaha, NE.

OCTOBER 19, 1994 — Distinguished Lecture Series, William J. Hoskins, M.D.

NOVEMBER 9, 1994 • Distinguished Lecture Series - Herman I. Libshitz, M.D. BTNRH Auditorium.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite 2130, Omaha, NE 68131.

BERGAN MERCY MEDICAL CENTER

OCTOBER 14, 1994 • Changing Concepts of Congestive Heart Failure, a symposium for primary care physicians. 12:00 - 4:30 p.m. Bergan Mercy Medical Center, 7500 Mercy Road, a, NE 68124. $25 registration fee. Guest faculty - J.Thomas Heywood, M.D. and Stuart D. Katz, M.D. To register call Bergan Mercy Continuing Medical Education at (402) 398-6192.

MAYO FOUNDATION

FEBRUARY 1-8, 1995 — Update in Clinical Neurophysiology, Mayo Clinic, Rochester, MN.

FEBRUARY 4-8, 1995 — Selected Topics In Internal Medicine, Silverado Resort, Napa Valley, CA.

FEBRUARY 9-11, 1995 — Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management, Silverado Resort, Napa Valley, CA.

MARCH 24-26, 1995 — Advances in Clinical Anesthesiology, Silverado Resort, Napa Valley, CA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

SEPTEMBER 15-17, 1994 — Fall Session, Cornhusker Hotel, Lincoln.

APRIL 27-30, 1995 — Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

UNIVERSITY OF NEBRASKA MEDICAL CENTER EMERGENCY MEDICAL SERVICES

JULY 21-22, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

SEPTEMBER 22-23, 1994, THURSDAY-FRIDAY— Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.0 Hours ACEP Category I. Fee: $550.

SEPTEMBER 24, 1994, SATURDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee $110.

SEPTEMBER 24, 1994, SATURDAY — Advanced Trauma Life Support (ATLS) Reverification, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 3 Hours AMA Category I, 3 Prescribed Hours AAFP, 3 Hours ACEP CAtegory I. Fee: $185.

OCTOBER 3-4, 1994, MONDAY-TUESDAY — Advanced Live Support in Obstetrics (ALSO). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Family Physicians, Obstetricians, General Practitioners, Emergency Physicians, Surgeons, Nurse Midwives, Obstetrical Nurses. Credit: 14 Hours AMA Category I, 16.0 Prescribed Hours AAFP. Fee: $300 - Physicians, $225 - Nurses.

OCTOBER 10-11, 1994, MONDAY-TUESDAY— Pediatric Advanced Life Support (PALS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses. Credit: 13 Hours AMA Category I. Fee: $175.

OCTOBER 20-21, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA CAtegory I, 14.5 Hours Prescribed Hours AAFP. Fee: $195.

OCTOBER 24-25, 1994, MONDAY-TUESDAY — Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.9 Hours ACEP Category I. Fee: $550.

OCTOBER 31 - NOVEMBER 1, 1994, MONDAY-TUESDAY — Trauma Nurse Core Course (TNCC), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience - Nurses. Credit: 18 CECH's of BCEN's Category of Clinical. Fee: $210 - Non-ENA Members, $175 - ENA Members.

NOVEMBER 7-8, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

DECEMBER 1, 1994, THURSDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.

DECEMBER 2, 1994, FRIDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

DECEMBER 2, 1994, FRIDAY — Pediatric Advanced Life Support (PALS) Instructor, University of Nebraska Medical Center Campus, Omaha, Nebraska. Credit: 4 Hours AMA Category I, 4 Hours Prescribed Hours AAFP. Fee $50.

For further information: Contact Cindy Hanssen, University of Nebraska Medical Center, Center for Continuing Education, 600 So 42nd Street, Omaha, Nebraska 68198-5651. Call (402) 559-5919 or use our toll free MD ADVANTAGE NUMBER AND ASK FOR CONTINUING EDUCATION (1-(800)652-1095 NATIONWIDE. FAX NUMBER (402) 559-5915.

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SEPTEMBER 17, 1994, SATURDAY — 7th Annual Internal Medicine Update, University of Nebraska Student Union, Lincoln, Nebraska. Target Audience: Emergency Medicine Physicians and others who provide care in the ER, Fee: $45.

SEPTEMBER 26, MONDAY, — OCTOBER 1, 1994, SATURDAY — Emergency Medicine, 1994, Center for Continuing Education, UNMC, Omaha, Nebraska, Target Audience: Emergency Medicine Physicians and others who provide care in the ER. Fee: $700.

OCTOBER 7, 1994, FRIDAY AFTERNOON — University of Nebraska College of Medicine Alumni Day (in conjunction with the Omaha Midwest Clinical Society Meeting), University

of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience: College of Medicine Alumni.

OCTOBER 8-12, 1994, SATURDAY - WEDNESDAY — North American Society of Pediatric Gastoenterology and Nutrition, Westin Galleria Hotel, Houston, Texas. Target Audience: Physicians and scientists interested in the field of pediatric gastoenterology and nutrition.

OCTOBER 14-17, 1994, FRIDAY EVENING-MONDAY — Advanced Curriculum on Women's Health - Part II, Adam's Mark, Philadelphia, Pennsylvania, Target Audience: Primary Care Physicians.

OCTOBER 19, 1994, WEDNESDAY — Advanced in Acid Related Diseases, Omaha Marriott, Omaha, Nebraska. Target Audience: Primary Care Physicians.

OCTOBER 22, 1994 — Transfusion Medicine, University of Nebraska Medical Center. Target Audience: Surgeons and Anesthesiologists.

NOVEMBER 12, 1994, SATURDAY— Evaluation and Management of the Swollen Extremity, UNMC, College of Nursing, Omaha, Nebraska. Target Audience: Primary Care Physicians and Nurses.

DECEMBER 1-3, 1994, THURSDAY-SATURDAY — Obstetrics and Gynecology Conference, Bally's, Las Vegas, Nevada. Target Audience: Primary Care Physicians, Obstetricians and Gynecologists. Fee: $275.

MARCH 5-10, 1995, SUNDAY-FRIDAY — 15th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MARCH 27-APRIL 7, 1995, 11 DAYS — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

APRIL 24-MAY 5, 1995, 11 DAYS — Family Practice Review , Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

JUNE 2-3, 1995, MONDAY-TUESDAY— Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

JUNE 9-10, 1995, FRIDAY-SATURDAY — 3rd Annual Diagnostic Dilemmas in Women's Health Care, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Physician Assistants. Fee: $200.

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NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

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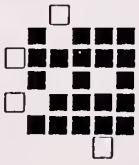

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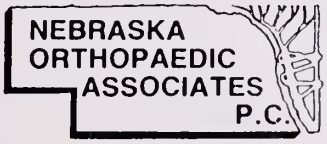

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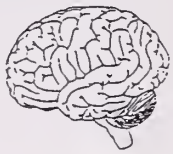

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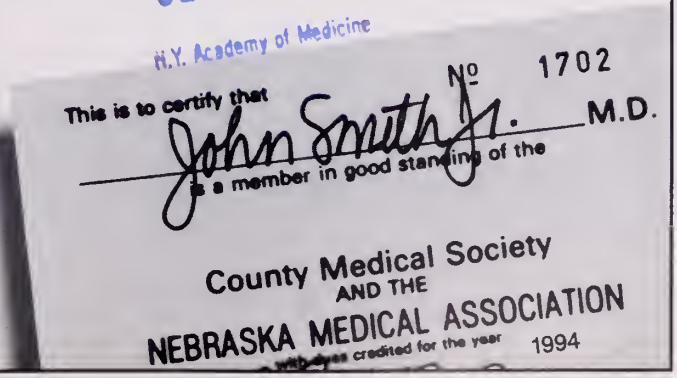

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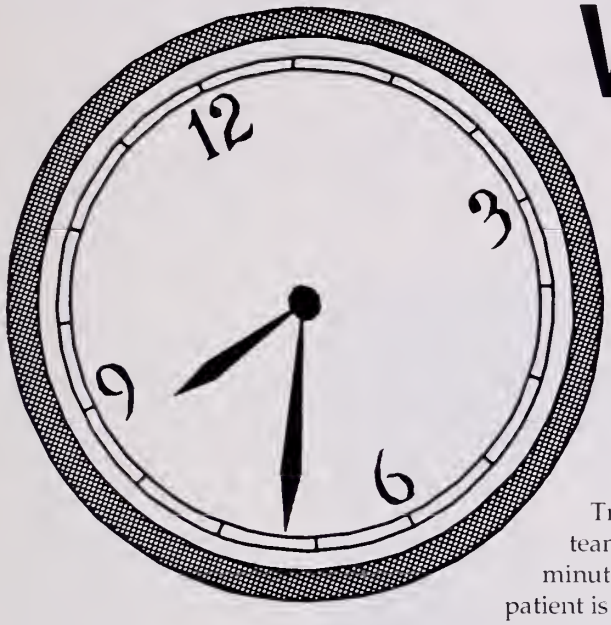

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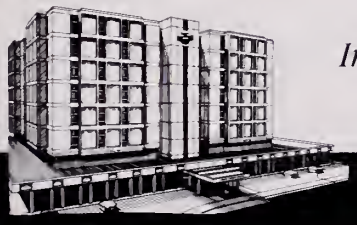

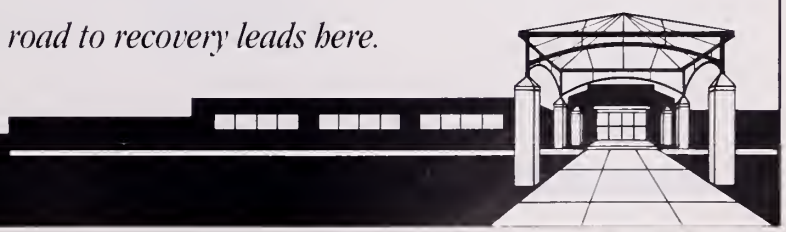

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CORRECTION: The cover picture on the September issue entitled "Grandma's", was an oil and acrylic painting by Gene Roncka of Ashland, Nebraska.

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AMA NEWS NOTES

AMA OPPOSES WORK FORCE QUOTAS IN REFORM BILLS

In a letter to all members of the Senate, the AMA endorsed an amendment that would eliminate work force allocation requirements from health system reform legislation.

The amendment to S. 2351, sponsored by Sens. Daniel Patrick Moynihan (D, N.Y.) and Robert Packwood (R, Ore.), "would create an environment in which the work force planning process could operate in a flexible and unencumbered manner, without mandating targets or setting quotas utilizing arbitrary ratios," the AMA said.

The letter also noted the AMA recognizes the nation's need to train more primary care physicians and supports establishing appropriate funding to reach that goal.

Flexible work force planning would respond to changing patient needs, new technology and assure medical students' career choices.

"We do not believe that [this] is best achieved through rigid quotas such as those found in the Mitchell bill," the letter said.

"We support positive incentives, such as loan forgiveness, to encourage primary care practice."

"We believe that legislation establishing work force planning should not prejudge the outcome . . . by setting in statute mandated targets for the size or specialty mix of the physician work force."

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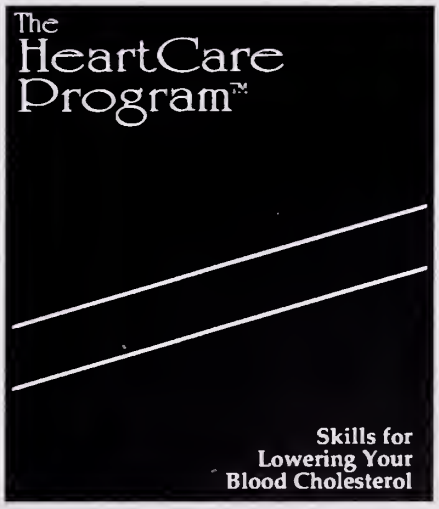

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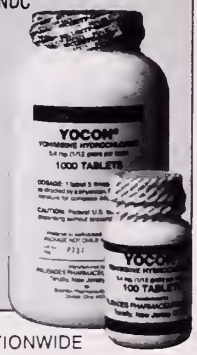

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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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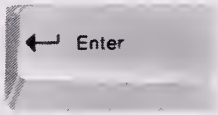

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You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

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- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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PRESIDENT'S PAGE

Restructuring the Nebraska Medical Association: Positioning For the Future

FREDERICK F. PAUSTIAN, M.D.

During the course of the many deliberations concerning the problems, issues, economics, and politics associated with health system reform, development of physician organizations, and anti-trust laws, I was struck by the thought that the Nebraska Medical Association organizationally is not well suited to being an effective force either locally or state wide. Discussion of the concern with a variety of members of the Association indicated a similar sense of discomfort or unrest. Very early in the course of my presidency a meeting of commission and committee chairpersons was held concerning their respective charge, goals and objectives. Again, there was identification of the need for restructuring the organization of the Association so as to be more effective in the management of the problems with which physicians are confronted. A working group was identified comprised of Joel Johnson, M.D., Chairholder, Commission on Association Affairs; Robert Shapiro, M.D., Immediate Past President; Darroll Loschen, M.D., Past President; David Bacon, M.D., President-Elect; Bill Schellpeper, Executive Director; and myself. An initial think tank meeting was held in York, Nebraska, on August 4, 1994, minus Dr. Shapiro who had another commitment.

Preliminary discussion suggested the Association's federation of county medical societies was not very effective due to the fact that most counties throughout the state had very few physicians and, therefore, lacked "critical mass." It was appreciated, however, that the county medical societies, primarily through individual physicians, had significant influence within their respective county and provided an excellent method for representation of all locales and physicians throughout the state to the House of Delegates of the Association.

So as to retain the benefits of the county medical society organization system, but at the same time develop units of physicians with a sufficient number of doctors/unit to provide critical mass and have impact, the following concept evolved.

1. Discontinue the current organizational structure consisting of 12 councilor districts, in as much as most are too small in terms of physician numbers to have significant influence and their only purpose is the management of ethics and grievance problems through the physician councilor of the district. Realistically, the only elements which are active in this respect are Districts I and II through the Metropolitan Omaha Medical Society and the Lancaster County Medical Society, respectively. All other ethics and grievance problems are usually managed through the Board of Councilors at the level of the state Association.

Frederick F. Paustian, M.D.

2. Restructure the state Association into six to eight geographically-defined regions which have approximately one hundred physicians per region, at the minimum, but maintain the integrity of the county boundaries.

3. When defining the boundaries of each region, consider related medically identifiable functions and services so as to provide for cohesiveness among the physicians by virtue of the necessity to function together as medical service units. Obvious medical functions already in operation under the auspices of the State of Nebraska are districts or regions established by the Department of Health as regards Community Health Services and Emergency Medical Services, and Medicaid under the direction of the Department of Social Services. It is therefore warranted to communicate with the Departments of Health and Social Services to determine their interest in developing

common medical service districts or regions which would also fulfill the needs of the organizational restructuring of the Nebraska Medical Association.

4. Such a functional regionalization of the Nebraska Medical Association could well result in significant physician influence on social issues, government medical issues, delivery of health care, and the business aspect of the practice of medicine, as well as impact upon the Nebraska Medical Association. So as to have such an effect, each region, of necessity, would have to formulate a constitution, articles and bylaws thereby establishing their own organizational structure and purpose. Furthermore, with approximately one hundred physicians per region or more and an appropriate dues structure, part-time to full time staff could be employed to facilitate the functions.

5. With the establishment of the regional organization, more effective representation to the Association Board of Directors might be obtained through the election of Board members by region rather than the current "at large" members as elected by the House of Delegates. The county society representation to the House of Delegates could remain as is with probably some modification of representation based on number of physician members per county to provide better representation of members for the larger county medical societies. In a certain sense a house and senate would be created but the final authority for all action would remain with the House of Delegates.

6. Through regional representation on the Board of Directors, more effective communication should be possible from all portions of the state to the leadership of the organization. A larger Board would permit internal committees of at least three members each to focus on specific problems followed by reports to the full Board. A more meaningful position of responsibility for the members of the Board of Directors might also be affected through having individual members of the Board serve as chairholders of each commission. By so positioning the members of the Board and increasing the frequency of the Board of Directors meetings, a much more knowledgeable and effective Board should evolve as a result of the markedly improved communication emanating from the deliberations and recommendations of the commissions and their respective committees.

7. The commissions would remain the same with the exception of adding a Commission on Medical Socioeconomics. Each designated committee of the President or of the Board would have a specific reporting responsibility to one of the commissions based on commission charge and committee function, permitting both a focused as well as a broader perspective review of all deliberations. Thus the new Commission on Medical Socioeconomics would receive reports from the Committees on Health Care Insurance and Medical Delivery Systems, PRO, Medicare and Medicaid. The Commission on Public Affairs would receive reports from new committees on patient advocacy and physician advocacy. Every existing or proposed committee would be assessed as to need and, if retained, aligned with a commission.

8. The Executive Committee of the Board comprised of the President, President-Elect, Immediate Past President, and Secretary-Treasurer should continue so as to permit rapid response and, if necessary, action on acute issues.

The above reorganization skeleton concept is presented to you as a member for your individual, thoughtful consideration and comment. There are many, many ramifications which must be deliberated. Among the benefits which are anticipated is a much improved democratic system for management of the affairs of the Association in an expedient manner. It is believed to have the potential to increase physician interrelationships, especially within the geographically-defined regions which have a functional purpose. A hoped for result, as a consequence for the medical service functions of each region and the enhanced representation and communication to the leadership, will be an increase in membership driven by the necessity to be an involved participant. There may well be the development of physician organizations within the regions which would further enhance the role of physicians in the determination of health system reform, be it either government or private industry in origin. Additionally, the formation of regional organizations in our rural areas may be of major benefit in enhancing the organization and activities of the Alliance.

It is planned for the working group on restructuring the Nebraska Medical Association to continue its deliberations. As your comments and constructive criticisms are received, they will be incorporated into a plan, as deemed appropriate, for presentation at the spring meeting 1995, of the House of Delegates for full discussion. If the process for development and the revised structure and function are found to be acceptable by the membership, a major revision of the NMA Constitution Articles and By-laws will be prepared for your consideration, hopefully, in one to one and a half years.

ORIGINAL ARTICLE

The University of Nebraska's College of Medicine Primary Care Community Education Networks

PAUL M. PAULMAN, M.D.,
UNMC Director Rural Preceptorship,
Rural Primary Care Block and Longitudinal Clincal Experience

IT is important for medical schools to provide primary care training and experience. This is especially true in Nebraska where many of the people in our state live in urban and rural areas which are medically underserved. Couple this with the fact that a large number (over 10%) of family physicians in our rural areas are approaching retirement age and it becomes obvious that Nebraska needs new primary care physicians to meet the health care needs of its population.

The University of Nebraska Medical Center (UNMC) has established extensive pre-ceptorship networks for the education of medical students. Freshman rotations with the community preceptor start to give the student a "real world" exposure to the practice of primary care medicine. Some of the benefits of rotations with community preceptors include introducing the student to the community on a professional level, vitalizing (or re-vitalizing) the students' desire to learn, and helping the students place basic science and clinical learning experiences in an integrated context. Students value the one-to-one interaction with the preceptor and, in many cases, lifelong mentor and/or advisor relationships are formed from the preceptorship experiences. Students also cite the chance to practice and integrate skills with freedom from competition by other learners and the progressive independence granted to them as being highlights of UNMC's precep-torship experiences. There is some evidence to suggest the Nebraska's preceptorship experiences have led to students choosing careers in family practice.[1,2,3] The benefits to preceptors include closer ties to UNMC, the chance to teach and interact with future colleagues, recruitment opportunities, and continuing medical education credit offered through the American Academy of Family Physicians (Figure 1).

FIGURE 1
UNMC'S COMMUNITY EXPERIENCES BY YEAR

YEAR 1 FRESHMAN		YEAR 2 SOPHOMORE	YEAR 3 JUNIOR	YEAR 4 SENIOR
Longitudinal Clinic (Required) Monthly)	Primary Care Block Rotation 3 Weeks (Summer) (Required)	Longitudinal Clinic (Required) Monthly)	Rural Preceptorship 8 Weeks (Required)	Extended Rural Preceptorship 6 Months (Elective)

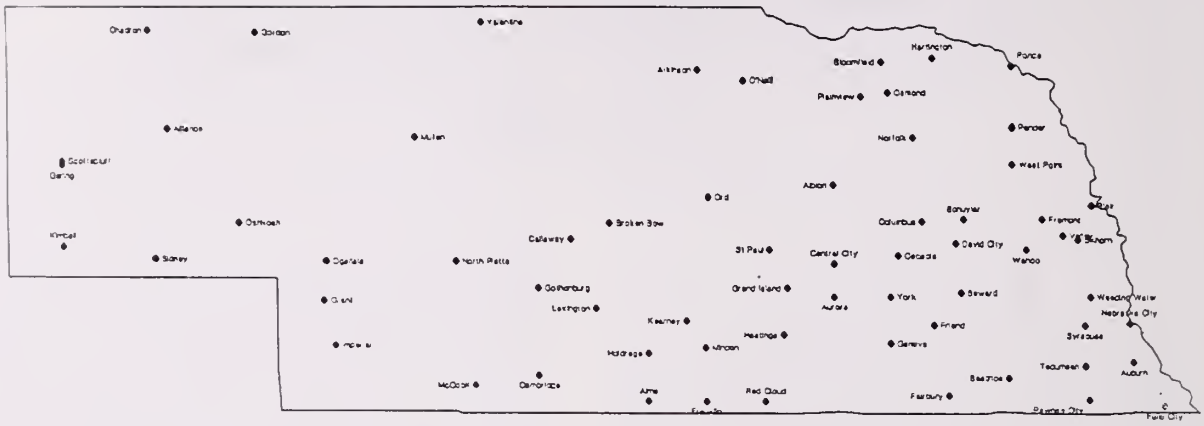
RURAL FAMILY PRACTICE PRECEPTORSHIP JUNIOR STUDENT LEVEL

> "The place where my daughter told me she learned to be a physician was during UNMC's rural family practice preceptorship".
> *Robert Waldman, M.D., Former Dean, University of Nebraska College of Medicine, Former Vice President, American Association of Medical Colleges.*

The University of Nebraska Medical Center has had a one or two month rural preceptorship for senior medical students since 1949. This preceptorship is the fourth oldest such experience in the nation and had been required for all medical students since 1971. At eight weeks, it is the longest required rural preceptorship in the nation. This preceptorship utilizes family physicians in rural Nebraska outside of the Omaha and Lincoln metropolitan areas. The preceptors teach, house, and feed students during the preceptorship. Students consistently rate the rural preceptorship among the most valuable clinical experiences of their training. The students enjoy the intense working relationship with their preceptor, the independence, primary care patient contact, and the opportunity to work in a health care delivery system other than a tertiary care hospital. The 143 perceptors provide over 54,000 student contact hours for the University of Nebraska Medical Center annually (Figure 2). This experience has been primarily a senior year rotation.

*Reprints request and correspondence to: Steven K. Krueger, M.D., F.A.C.C., 1919 So. 40th St., Suite 300, Lincoln, NE 68506.

FIGURE 2
M3 PRECEPTOR SITES FAMILY PRACTICE - UNMC



Starting in 1994, the rural preceptorship will be placed in the junior year along with the other required core clerkships in OB/GYN, internal medicine, pediatrics, surgery and psychiatry. A extended (six months) elective rural preceptorship for senior students is being planned and developed and will be available in 1995-96.

> "The rural preceptorship has a positive impact on recruiting for rural health facilities, the University programs are definitely helping to improve rural health".
>
> *Gayle Primrose, Administrator, Boone County Community Hospital, Albion, Nebraska.*

> "The rural preceptorship is beneficial to both the physicians and students, and our community has enthusiastically accepted the students".
>
> *Dr. Darroll Loschen, UNMC Family Physician Preceptor, Past President, Nebraska Medical Association, York, Nebraska.*

RURAL PRIMARY CARE BLOCK ROTATION FRESHMAN ROTATION

This rotation allows students an opportunity to work with a rural primary care physician (general internist, general pediatrician, or family physician) for a three week rotation at the end if their freshman year. The goals of the rotation are similar to those of the junior/senior rural preceptorship, i.e., the students observe and participate in the care of the preceptor's patients to the limits of the student's abilities, and the level of the preceptor's comfort, live in and become part of the rural community and become familiar with the rewards and challenges of rural primary care. Students have had opportunities for early rural primary care exposure since 1972. The primary care block rotation became a required course for all UNMC students in 1993. The first group of students completing the required block rotation rated it extremely high - some stated it was the best educational experience of their freshman year. Evaluations indicate these students showed an increase in their clinical confidence as a result of their primary care block rotation. As with the junior/senior rural preceptorship, these 61 preceptors house and feed their students and provide over 14,000 student contact hours per year (Figure 3). This interdisciplinary effort is another example of UNMC's commitment to rural primary care.

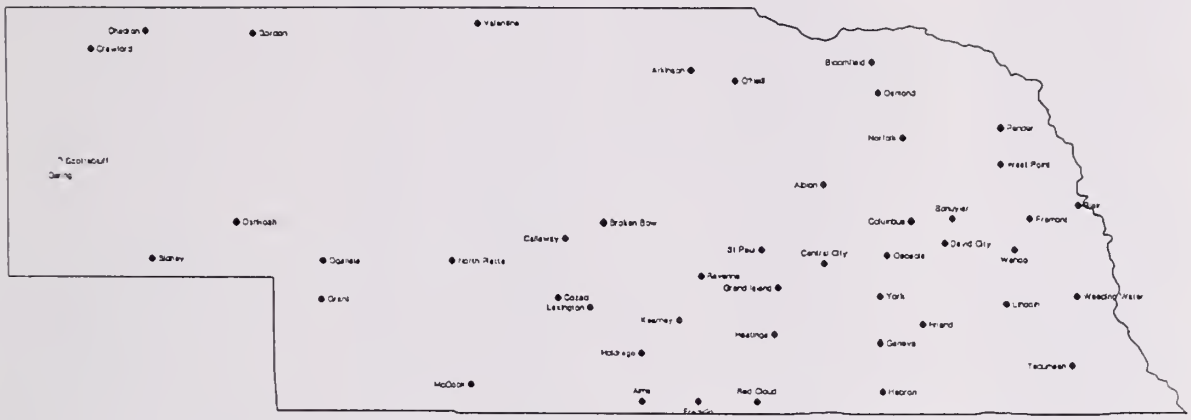
> "I really enjoyed the welcome feeling from the community and the doctors' willingness to teach".
>
> *Bill Butz, sophomore medical student at the University of Nebraska Medical Center, Past-President, Family Practice club, UNMC.*

> "We look forward to having students work with us so they can see physicians enjoying the practice of rural medicine".
>
> Margaret Cavanaugh-Boyer, M.D., Family Physician Preceptor,UNMC, Mullen, Nebraska.

LONGITUDINAL CLINIC EXPERIENCE - FRESHMAN AND SOPHOMORE LEVEL

Medical students at the University of Nebraska College of Medicine also get a chance to work with urban primary care physicians during their first two years of training. Freshman and sophomore students spend one half-day per month in the office of a general internist, general pediatrician or family physician throughout their first two academic years. This experience complements the primary care block rotation and also provides students with an opportunity to practice history and examination skills, which are taught longitudinally over the first two years, also taught mostly by primary care physicians and medical residents in Omaha. The students observe and participate in the preceptors' practice,

FIGURE 3
M1 PRIMARY CARE RURAL ROTATION SITES UNMC



with increasing participation depending on the increase of the students' knowledge and skills. The students value their longitudinal clinic experience and rate it very highly. The interest and teaching skills of the preceptors draw particularly high praise from the students. This program was started in 1992 and is required for all UNMC medical students. The 73 urban preceptors provide over 6,000 student contact hours per year.

> "I want more of the longitudinal clinic - twice as much as we have now."
> *Saswata Roy, freshman medical student, University of Nebraska Medical Center.*

> "Our students are enthusiastic and want to learn. We like this program".
> *Dr. John Hoesing, Internal Medicine Preceptor, Longitudinal Clinic, Omaha, Nebraska.*

UNMC's community primary care teaching networks provide what is probably the most extensive early community experience for medical students in the nation. These rotations provide the students with multiple levels of learning with opportunities for diversity and continuity of experience for clinical patient encounters. The networks provide several benefits to the students, including vitalizing the desire for learning, integration of skills, independence, developing relationships and community preceptors, an opportunity to examine other delivery systems outside of a tertiary care hospital, and an active learning experience with adult learning principles. Benefits to preceptors include an opportunity to develop a relationship with a student, recruiting, re-vitalization of the preceptor's desire to learn and closer ties to UNMC and its educational resources. Advantages to the University of Nebraska include improved education for the students, tapping the expertise of the preceptors, the opportunity for the students to have large numbers of patient contacts and closer ties with the preceptors to UNMC. There is also some evidence to suggest that these experiences help recruit students into primary care fields, especially family practice.

None of these opportunities for our students would be possible without the incredible volunteerism of our community physicians. There is no other group of physicians in the nation who have given so much for the education of so many students. Over 80% of the physicians who practice in rural Nebraska have experienced one of more of these rural programs as students during their medical school training. The community physicians rightfully take great pride in the quality of their teaching and take an active role in the governance and management of the rural educational experiences for medical students through the Preceptorship Committee, chaired by Dr. Stuart Embury of Holdrege, Nebraska.

As we move into the "brave new world" of health care in the 1990's and beyond, there will be increasing need for medical students to have learning experiences with community physicians. If you think this experience will help students become "physicians", we need your help. If you would like information about how you can participate in any or all of these programs. please contact Dr. Paul Paulman, Department of Family Practice, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, Nebraska 68198-3075.

REFERENCES

1. Chaulk, C.P., Paulman, P.M., Bass R.L. Physicians' Assessments of a Rural Preceptorship and its Influence on Career Choice and Practice Site. J. Med Educ. Vol 62(4). 1987. pp. 349-351.

2. Bass, R.L., Paulman, P.M. The Rural Preceptorship as a Factor in the Residency Selection, the Nebraska Experience. J. Fam. Prac. Vol. 17(4) 1983. pp. 199-203.

3. Paulman, P.M., Davidson-Stroh, L. The Effect of a Senior Rural Family Practice Preceptorship on Medical Students' Residency Choice. FPRJ. 13(40) pp. 385-389.

TABLE 1 — RURAL PRECEPTORS FOR JUNIOR STUDENTS

J.D. Akerson, M.D.
Sidney, Nebraska
A.J. Alderman, M.D.
Chadron, Nebraska
Milo Anderson, M.D.
Fremont, Nebraska
Charles Ashby, M.D.
Geneva, Nebraska
Kenneth Bagby, M.D.
Blair, Nebraska
Craig Bartruff, M.D.
Gothenberg, Nebraska
William Becker, M.D.
Norfolk, Nebraska
Emmanuel Beyers, M.D.
McCook, Nebraska
Timothy Biga, M.D.
Norfolk, Nebraska
Richard Blatny, M.D.
Fairbury, Nebraska
David Borg, M.D.
Falls City, Nebraska
Paul Bottom, M.D.
Grant, Nebraska
Steve Boyer, M.D.
Mullen, Nebraska
Richard Brouilette, M.D.
York, Nebraska
Richard Carleton, M.D.
McCook, Nebraska
Mark Carlson, M.D.
David City, Nebraska
Kaye Carstens, M.D.
Fairbury, Nebraska
Fred Catlett, M.D.
Hastings, Nebraska
Margaret Cavanaugh-Boyer, M.D.
Mullen, Nebraska
Tom Christensen, M.D.
Minden, Nebraska
Richard Clark, M.D.
Gering, Nebraska
Gary Conell, M.D.
North Platte, Nebraska
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Calvin Cutright, M.D.
Sidney, Nebraska
Clarence Davis, M.D.
Osceola, Nebraska
Timothy Davy, M.D.
Norfolk, Nebraska
David Demuth, M.D.
York, Nebraska
John Denker, M.D.
Valley, Nebraska
Clinton Dorwart, M.D.
Sidney, Nebraska
Francisco Dozon, M.D.
Norfolk, Nebraska
William Eaton, M.D.
Fremont, Nebraska
Scott Ehresman, M.D.
Holdrege, Nebraska
Stuart Embury, M.D.
Holdrege, Nebraska
Douglas Fairbairn, M.D.
Imperial, Nebraska
Wendell Fairbanks, M.D.
Elkhorn, Nebraska
William Fitzgibbons, M.D.
Elkhorn, Nebraska
John Ford, M.D.
Lexington, Nebraska
Bruce Forney, M.D.
Alliance, Nebraska
Richard Freuhling, M.D.
Grand Island, Nebraska
Jerome Gacke, M.D.
Central City, Nebraska
Donald Gentry, M.D.
Gering, Nebraska
Richard Gentry, M.D.
Blair, Nebraska
Marcia Goering, M.D.
David City, Nebraska
Scott Green, M.D.
West Point, Nebraska
John Grove, M.D.
McCook, Nebraska
Paul Grow, M.D.
Imperial, Nebraska
Michael Hanich, M.D.
Kearney, Nebraska
Robert Hanlon, M.D.
Chadron, Nebraska
John Hansen, M.D.
Wahoo, Nebraska
Daniel Harkins, M.D.
Gering, Nebraska
Lawrence Helmick, M.D.
Kearney, Nebraska
Joe Hermsen, M.D.
Beatrice, Nebraska
David Hoelting, M.D.
Pender, Nebraska
Jeffrey Hollis, M.D.
Geneva, Nebraska
Lynne Holz, M.D.
Aurora, Nebraska
Patrick Hotovy, M.D.
York, Nebraska
Allen Hunt, M.D.
Valentine, Nebraska
John Huscher, M.D.
Norfolk, Nebraska
Steven Husen, M.D.
Grand Island, Nebraska
Joel Hutchins, M.D.
Gordon, Nebraska
Richard Jackson, M.D.
Pawnee City, Nebraska
Loren Jacobsen, M.D.
Broken Bow, Nebraska
Verlin Janzen, M.D.
Nebraska City, Nebraska
Richard Jay, M.D.
Alma, Nebraska
Mark Jobman, M.D.
Aurora, Nebraska
David Johnson, M.D.
Osmond, Nebraska
Kurt Johnson, M.D.
Ogalalla, Nebraska
Michael Johnson, M.D.
Hastings, Nebraska
Tammy Johnson, M.D.
Cambridge, Nebraska
Mark Jones, M.D.
Lexington, Nebraska
Harold Keenan, M.D.
Osh Kosh, Nebraska
Richard Klug, M.D.
McCook, Nebraska
Jeff Knerl, M.D.
Ponca, Nebraska
Randy Kohl, M.D.
Albion, Nebraska
Bart Kolste, M.D.
Ogallala, Nebraska
Anthony Kusek, M.D.
Albion, Nebraska
Alan Langvardt, M.D.
Beatrice, Nebraska
Luke Lemke, M.D.
Columbus, Nebraska
James Long, M.D.
Alma, Nebraska
Darroll Loschen, M.D.
York, Nebraska
Gerald Luckey, M.D.
David City, Nebraska
Peter Lueninghoener, M.D.
O'Neill, Nebraska
Paul Madison, M.D.
Nebraska City, Nebraska
Steven Mahnke, M.D.
Central City, Nebraska
Ben Martin, M.D.
Pender, Nebraska
Thomas Martin, M.D.
Ord, Nebraska
Maurice Mathews, M.D.
St. Paul, Nebraska
Daniel Mazour, M.D.
Red Cloud, Nebraska
Linda Mazour, M.D.
Franklin, Nebraska
Patrick McCarvel, M.D.
Valley, Nebraska
Robert McKeeman, M.D.
Friend, Nebraska
Robert McLellan, M.D.
Beatrice, Nebraska
David McMaster, M.D.
Auburn, Nebraska
Thomas McKnight, M.D.
Fremont, Nebraska
Scott McPherson, M.D.
Geneva, Nebraska
Leo Meduna, M.D.
Wahoo, Nebraska
Joe Miller, M.D.
Lexington, Nebraska
Lynnette Moseman, M.D.
Ogallala, Nebraska
Delwyn Nagengast, M.D.
Bloomfield, Nebraska
Robert Penor, M.D.
Chadron, Nebraska
Ed Pierce, M.D.
Alliance, Nebraska
James Plate, M.D.
Kimball, Nebraska
Mark Ptacek, M.D.
O'Neill, Nebraska
Gary Rademacher, M.D.
Nebraska City, Nebraska
Robert Rasmussen, M.D.
Chadron, Nebraska
Richard Reiner, M.D.
Holdrege, Nebraska
Roselyn Remington, M.D.
Schuyler, Nebraska
Richard Dane Robinson, M.D.
Norfolk, Nebraska
Brad Rodgers, M.D.
Kearney, Nebraska
Harry Salyards, M.D.
Hastings, Nebraska
Phyllis Salyards, M.D.
Hastings, Nebraska
Steven Schulz, M.D.
Holdrege, Nebraska
Monty Sellon, M.D.
Fremont, Nebraska
Steven Senseney, M.D.
Valentine, Nebraska
Mark Serbousek, M.D.
McCook, Nebraska
Gary Settje, M.D.
Grand Island, Nebraska
Ronald Sheppard, M.D.
Callaway, Nebraska
Keith Shuey, M.D.
Tecumseh, Nebraska
Craig Shumard, M.D.
Fairbury, Nebraska
Berl Spencer, M.D.
Ogalalla, Nebraska
Margaret Stockwell, M.D.
Gordon, Nebraska
Michael Sullivan, M.D.
Aurora, Nebraska
Tom Surber, M.D.
Norfolk, Nebraska
Victor Thoendel, M.D.
David City, Nebraska
Steven Thomas, M.D.
York, Nebraska
Dean Thomson, M.D.
Nebraska City, Nebraska
Ed Vahle, M.D.
Seward, Nebraska
Charles Vlach, M.D.
Hartington, Nebraska
Carol Wechmuller, M.D.
Blair, Nebraska
Robert Weldon, M.D.
Nebraska City, Nebraska
Tom Werner, M.D.
Valentine, Nebraska
John West, M.D.
York, Nebraska
Wayne Weston, M.D.
Lexington, Nebraska
Timothy Widhelm, M.D.
Aurora, Nebraska
John Wilcox, M.D.
Aurora, Nebraska
Chauncy Wilkins, M.D.
Blair, Nebraska
Orlyn Wingert, M.D.
Blair, Nebraska
Charlotte Wirges, M.D.
Holdrege, Nebraska
Donald Wirth, M.D.
Grand Island, Nebraska
Gill Wright, M.D.
Syracuse, Nebraska
Milton Zadina, M.D.
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TABLE 2
RURAL PRECEPTORS FOR FIRST YEAR STUDENTS

FAMILY PHYSICIANS
J.D. Akerson, M.D.
Sidney, Nebraska

Charles Ashby, M.D.
Geneva, Nebraska

Steve Boyer, M.D.
Mullen, Nebraska

James Bridges, M.D.
Fremont, Nebraska

Doug Campbell, M.D.
Missouri Valley, Iowa

Lawrence Carllson, M.D.
Plattsmouth, Nebraska

Gary Conell, M.D.
North Platte, Nebraska

Clarence Davis, M.D.
Osceola, Nebraska

Clinton Dorwart, M.D.
Sidney, Nebraska

Scott Ehresman, M.D.
Holdrege, Nebraska

Chris Elliott, M.D.
Fremont, Nebraska

Gary Ensz, M.D.
Auburn, Nebraska

Beth Ernst, M.D.
Kearney, Nebraska

Dave Felber, M.D.
Laurel, Nebraska

Richard Fitch, M.D.
O'Neill, Nebraska

John Ford, M.D.
Lexington, Nebraska

Bruce Forney, M.D.
Alliance, Nebraska

Jerome Fuhrman, M.D.
Gering, Nebraska

Richard Gentry, M.D.
Blair, Nebraska

Gay Gilmore, M.D.
Crawford, Nebraska

Jeff Gotschall, M.D.
Columbus, Nebraska

R.D. Hanlon, M.D.
Chadron, Nebraska

Joe Hermsen, M.D.
Beatrice, Nebraska

Al Herrington, M.D.
Omaha, Nebraska

Brad Rodgers, M.D.
Kearney, Nebraska

Leslie Schlake, M.D.
Norfolk, Nebraska

Monty Sellon, M.D.
Fremont, Nebraska

Ronald Sheppard, M.D.
Callaway, Nebraska

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Tecumseh, Nebraska

Michael Skoch, M.D.
Hastings, Nebraska

Steven Titus, M.D.
Omaha, Nebraska

Charles Vlach, M.D.
Hartington, Nebraska

Richard Ward, M.D.
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C.J. Weckmuller, M.D.
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Al Wilsey, M.D.
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Gill Wright, M.D.
Syracuse, Nebraska

Milton Zadina, M.D.
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INTERNISTS:
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Newton Mack, M.D.
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Todd Sorenson, M.D.
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John Wagoner, M.D.
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Fremont, Nebraska

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TABLE 3
LONGITUDINAL CLINIC EXPERIENCE PRECEPTOR LIST

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Ivan Abdouch, M.D.
Bellevue, Nebraska

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Mark Anderson, M.D.
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Robert Bass, M.D.
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Kathy Bliese, M.D.
Omaha, Nebraska

Bob Bowman, M.D.
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Wendell Burris, M.D.
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Kent Johnson, M.D.
Omaha, Nebraska

Harold Johnson, M.D.
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Timothy Lieske, M.D.
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Tom Magruder, M.D.
Omaha, Nebraska

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Papillion, Nebraska

Faroug Qaquish, M.D.
Omaha, Nebraska

Michael Sitorius, M.D.
Omaha, Nebraska

Jim Smith, M.D.
Omaha, Nebraska

John Smith, M.D.
Omaha, Nebraska

James Stageman, M.D.
Omaha, Nebraska

Greg Starr, M.D.
Omaha, Nebraska

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Omaha, Nebraska

Jeff Susman, M.D.
Omaha, Nebraska

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Omaha, Nebraska

Carol Weckmuller, M.D.
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Omaha, Nebraska

Dave Weeks, M.D.
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Kent Kronberg, M.D.
Omaha, Nebraska

Gary Lerner, M.D.
Omaha, Nebraska

Charles Look, M.D.
Omaha, Nebraska

Mary Mikuls, M.D.
Omaha, Nebraska

John Moore, M.D.
Omaha, Nebraska

Peter Murphy, M.D.
Omaha, Nebraska

Laura Nelson, M.D.
Omaha, Nebraska

Paul Nelson, M.D.
Omaha, Nebraska

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Omaha, Nebraska

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Omaha, Nebraska

Susanne Elsts, M.D.
Omaha, Nebraska

Richard Forsman, M.D.
Omaha, Nebraska

John Hoesing, M.D.
Omaha, Nebraska

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Council Bluffs, Iowa

Jack Lewis, M.D.
Omaha, Nebraska

Merle McAlevy, M.D.
Omaha, Nebraska

Ann Morre, M.D.
Omaha, Nebraska

Barry Munyon, M.D.
Omaha, Nebraska

David Olson, M.D.
Omaha, Nebraska

Mark Omar, M.D.
Omaha, Nebraska

Richard Osterholm, M.D.
Omaha, Nebraska

Anton Piskac, M.D.
Omaha, Nebraska

Jane Potter, M.D.
Omaha, Nebraska

John Sage, M.D.
Omaha, Nebraska

Lynn Scott, M.D.
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William Shiffermiller, M.D.
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ORIGINAL ARTICLE

The Nebraska Hospital-Medical Liability Act: A Successful Approach To Medical Malpractice Caps

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I. INTRODUCTION

THE Nebraska Hospital-Medical Liability Act (NHMLA or the Act), codified at Neb. Rev. Stat. §44-2801 et. seq., is one of the most conservative statutory attempts in the nation to place a limit on recoverable medical malpractice damages. Reflecting a nationwide concern with stemming the tide of excessive jury verdicts, many states in the United States have adopted a wide variety of statutory damage caps.

Most of those statutory attempts have been challenged on a variety of constitutional grounds. Nationwide, however, courts have split fairly evenly on those issues. Further, courts are now beginning to witness a "second generation" of constitutional issues as to statutory caps, focusing not so much on whether they should be applied, but on how they are applied. Like many other statutory attempts in a number of other states, the NHMLA was challenged and passed muster on a number of claims with respect to constitutionality.

While most courts and commentators recognize the necessity for such remedies due to what has been perceived as a medical malpractice crisis, legislators undoubtedly find themselves under close scrutiny to structure such statutes so as to not violate the provisions of State as well as the United States Constitutions. The Nebraska legislature has been successful in creating a statutory limitation on medical malpractice damages which has precluded runaway jury verdicts, has withstood constitutional challenge, has provided benefits to plaintiffs which they do not possess under common law remedies, and has likely contributed to one of the lowest average malpractice insurance premium rates in the nation.

II. PROVISIONS OF THE NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

The NHMLA was passed by the 1976 Legislature as an alternative method for resolving medical malpractice claims. The Act applies to professional liability problems associated with physicians, nurse anesthetists, and certain health care facilities such as hospitals. The ultimate goal of the Act is to encourage physicians to practice medicine in Nebraska, thereby ensuring the availability of competent medical and hospital services to the public in the State of Nebraska. This alternative was designed to provide prompt and efficient methods for eliminating nonmeritorious malpractice claims, efficient methods for resolving meritorious claims, improved availability and quality of medical care, reduction of the costs of medical care, and availability of malpractice insurance coverage at reasonable rates.[1]

A physician, nurse anesthetist, or hospital is not obligated to be included under the Act. If a physician or nurse anesthetist elects to be included, he or she must take affirmative action including sending proof of basic professional liability insurance coverage in the amount of $200,000/$600,000 for each occurrence. (In the case of hospitals and their employees, an aggregate liability amount of $1,000,000 for all occurrences shall be provided.) Additionally, participants must pay into the Excessive Liability Fund, administered by the Nebraska Department of Insurance, and display an approved notice of the election to be included under the Act.[2]

Patients are also not obligated to be included under the Act. A patient is "conclusively presumed" to be included under the Act, however, unless the patient takes affirmative action to exclude himself or herself from the Act. Such a patient must file an election of exclusion with the Insurance Director of the State of Nebraska prior to treatment and renew the election every two years. Additionally, the patient must notify the physician as to the election as soon as is "reasonable under the circumstances."[3]

If either the physician or patient in any professional medical liability claim has chosen to be excluded from the Act, there is no limit to monetary damages, and common law rules apply. If, on the other hand, both the physician and patient are included under the Act, the mon-

etary damage to the physician is limited to the amount of his or her basic insurance coverage. The total award, however, for any occurrence resulting in the injury or death of the patient may be as high as a) $500,000 for any occurrence on or before December 31, 1984, b) $1,000,000 for any occurrence after December 31, 1984, and on or before December 31, 1992, and c) $1,250,000 for any occurrence after December 31, 1992.[4]

The cap applies to all resulting damages, not just noneconomic. The differences between the physician's insurance coverage and the maximum award limit is paid out of an "Excessive Liability Fund," into which physicians qualified under the Act can be asked to pay up to an amount not to exceed 50% of the premiums of their basic insurance coverage.[5] The amount is set annually by the Nebraska Department of Insurance, and presently is 30%.

Other significant provisions include strict limitations on claims based on lack of "informed consent," and the optional use of a three physician/one attorney review panel to render advisory findings on claims after which some plaintiffs may choose to proceed on to court. And finally, the Act creates a residual malpractice insurance authority to write medical malpractice insurance for health care providers who have been declined by at least two commercial insurers. A limitation on the collateral source rule was enacted which reduces the size of judgment awards in some instances.[6]

III. COMMON CONSTITUTIONAL CHALLENGES NATIONWIDE

Courts nationwide have split fairly evenly on the subject of constitutionality of existing damage caps.[7] Early on, challengers of statutory caps usually relied on concepts of due process and equal protection. The former argument says that when the legislature abolishes a common-law remedy, it must provide some reasonable substitute or quid pro quo.[8] The latter challenge argues that state laws restricting recovery for injuries suffered by patients creates two classes of citizens. Those who are injured by the negligence of anyone other than by a physician may recover in full, while those who injured by a physician are limited in the amount they can recover.[9]

In the earliest challenges against such statutory attempts, courts generally concluded that such statutes passed muster under these provisions.[10] In the few instances where a cap was invalidated, it was generally where the statute was challenged on equal protection grounds, and the court applied a stricter standard than the "rational basis" test traditionally applied to social and economic legislation.[11]

While equal protection and due process arguments are continually raised, new arguments have emerged in more recent court challenges. The right to a jury trial as guaranteed by the Seventh Amendment to the United States Constitution and corresponding state constitutions is frequently raised. Arguments based on miscellaneous state constitutional guarantees are also quite prevalent including access to courts, remedy by due course of law, separation of powers, and prohibitions against special legislation.[12]

Finally, a "second generation" of legal issues related to the application and interpretation of caps has arisen. Three of the most frequently litigated disputes concern the following: 1) the number of caps that apply when there is more than one litigant entitled to damages, 2) the types of damages that are subject to the cap, and 3) the application of a particular statute to actions for wrongful death.[13] Many of the above challenges have been asserted against the NHMLA.

IV. CONSTITUTIONALITY OF THE NHMLA

The NHMLA, although one of the most conservative statutory caps in the nation, has successfully withstood constitutional attack. Though it remains apocryphal whether the Act has met its goal of attracting qualified physicians to the State of Nebraska to serve the medical needs of its residents, the Nebraska legislature has created a series of provisions which halt excessive jury verdicts, prevent windfalls to plaintiffs, and yet respect constitutional rights.

In 1977, the Nebraska Supreme Court rendered its findings as to a number of constitutional challenges against the NHMLA. In Prendergast v. Nelson,[14] the provision of the NHMLA providing for a medical review panel was attacked on the grounds that it violated a plaintiff's right to a jury trail. The Act survived this attack as the court noted that the then mandatory review panel had only the effect of "furnish[ing] the parties with the opinion of an expert panel."[15] As an option, the panel is effective in informing plaintiffs of the merits of their claims and inevitably weeding out nonmeritorious claims without acting as a bar to court and thereby violating one's constitutional right to a jury trial. The court continued, "If [the panel] determines there is no basis for [the claim], claimant is informed of what others think of the merits of his claim. If he disagrees, he still has access to the courts for a vindication of what he thinks his rights may be."[16]

A second allegation against the NHMLA was that the medical review panel would usurp the judicial functions granted to the judiciary by the Constitution of the State of Nebraska. Again the NHMLA survived the attack as the court noted that the panel's sole function is to provide an expert opinion based on the evidence. "It is not an arbitration board and has no authority to dispose of the action [but] should promote an early disposition of many cases by early settlement."[17] The Act in no way encroaches on the judiciary's function to resolve and pass judgments on a suit.

The NHMLA fared equally well against an equal protection challenge. The Nebraska Supreme Court found that the burdens of the growth of malpractice litigation and the prohibitive costs of malpractice insurance premiums, which are inevitably passed on to the public, provide a rational basis to sustain the Act.[18] A due process challenge failed as well, given the fact that no common law remedy is abrogated. The Act is a statutory alternative to the common law remedy. Any plaintiff may opt out of the provisions of the Act, and the common law remedies are then still available.

Finally, the NHMLA provision in which credit shall be applied to the verdict for nonrefundable insurance benefits was held not to impair the obligation of contract. Although the amount of judgment is reduced by the amount of insurance benefits paid to the plaintiff in order to avoid a windfall, nothing affects any outstanding contract.[19] As to the charge that the statute is not truly elective due to the insufficiency of notice to the plaintiff who may wish to opt out of the provisions of the Act, the court held that, as in many other areas, the argument fails as "[a]ll persons are charged with knowledge of the law."[20]

The Prendergast case actually contained differing opinions by several of the judges, but collectively the vote was three to four to overturn the law.[21] The Nebraska Constitution requires a concurrence by five justices to hold a law unconstitutional.[22] While the Supreme Court usually follows its prior opinions under the Stare Decisis doctrine, the court can reverse itself. Noteworthy is the fact that, of the seven judges who ruled on the Prendergast case in1977, only two still remain on the court, both of which sided with the dissent which found provisions of the Act to be unconstitutional.

V. SUCCESSES OF THE NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

The Nebraska Hospital-Medical Liability Act is an example of a conservative statutory cap on damages that is structured so as to avoid the pitfalls of other statutes that have not withstood constitutional attack. The Act, on its face, precludes possible runaway jury verdicts in excess of $1,250,000 and prevents windfalls to plaintiffs resulting from double payment of insurance benefits and a court judgment. Additionally, the Act carefully provides for several "weed out" mechanisms such as the medical review panel which encourage pre-trial settlement of meritorious claims and discourage further action on nonmeritorious claims. The Act also contains a provision allowing the court to review attorney's fees. The law states, "In all cases against a health care provider for malpractice or professional negligence, upon a motion of either party the court shall review the attorney's fees incurred by that party and allow such compensation as the court shall deem reasonable."[23]

Such provisions benefit patients every bit as much as they benefit physicians, as any costs such as for frivolous litigation or prohibitive malpractice insurance premiums will inevitably be passed on to the entire class of patients as a whole. After the Nebraska Supreme Court declared the Act constitutional in 1977, an argument remains as to the equitable impact the statute could have on a seriously injured patient.

Though a limitation of $1,250,000 on all damages resulting from the negligence of a physician is comparatively strict, the elective nature of the statute for patients prevents an undue restriction on the seriously injured patient. Any patient may choose to opt out of the statute and thereby retain all his or her remedies under the common law. In actuality, only a handful of patients have opted out. In many cases, however, the statutory remedy may provide even greater protection than the common law remedy.

Under the election, the Act establishes a fund that the claimant can access for the payment of any medical malpractice claim up to $1,250,000. Under the common law remedy, no such guarantee exists, and with physicians like the defendant in Prendergast v. Nelson, who were unable to obtain medical malpractice insurance, recovery of a substantial judgment could be quite remote. In addition, plaintiffs are assured the procedure of an impartial medical review panel to determine whether the health care provider met the applicable standard of care. The panel provides an option to plaintiffs whose meritorious claims may lead to out-of-court settlements following the findings of the panel, thereby avoiding expensive court costs and attorney's fees. Under amend-

ments made to the law several years ago, however, the pre-trial panel of physicians is now optional. The claimant may waive his or her right to a panel review and proceed to file an action directly in court.

Additionally, statistical data suggests that very few, if any, patients in Nebraska would be affected by the statutory limit. In 1993, the NHMLA paid nine claims out of its Excessive Liability Fund for a total of $2,001,001.[24] Thus, the average claim payment for the year 1993 was $222,333,[25] well below the statutory limitation of $1,250,000. In 1991, the year seeing the highest amount of money paid out on claims since the Act's inception, the average claim payment was only $466,368,[26] also well below the limitation which was at that time $1,000.000.

As of December 31, 1993, there was a total of $45,575,477 in the fund with $22,698,028 reserved for pending claims. Over the years, claims paid have not exceeded interest earned on the fund. The solvency of the fund is reviewed not only by Department of Insurance actuaries, but also by outside actuaries, usually biannually. Additionally, in the year 1993, for example, only 1.5% of the annual income was used to administer the fund.

Finally, physicians and patients alike are benefited as Nebraska physicians are paying some of the lowest medical malpractice insurance premiums in the nation. Hopefully, this fact assures that physicians do not "go bare," and that providers lower patient billings. As physicians in the majority of states are purchasing Class 3 doctor/mature claims-made rates primarily at $1,000,000/$3,000,000 policy limits, average annual premiums range from $5,388 in Arkansas to $43,001 in the city of Los Angeles and $48,718 in the city of Chicago.[27] Nebraska is included in a group of states requiring lower mandatory limits of coverage, $200,000/$600,000. The average Nebraska physician pays only $4,359 annually for medical malpractice insurance, second only to Indiana physicians who pay $4,350 annually for the same limits on coverage.[28]

VI. CONCLUSION

The Nebraska Hospital-Medical Liability Act places a limit on excessive jury verdicts and creates valuable options for plaintiffs while protecting physicians from frivolous claims. The NHMLA respects constitutional rights, while at the same time, has enabled physicians to enjoy some of the lowest medical malpractice insurance premiums in the nation. All of these results can only aid the State in achieving its goal of attracting qualified physicians who will then improve the availability and quality of health care for the residents of the State of Nebraska.

REFERENCES

1. Nebraska Hospital-Medical Liability Act, Neb. Rev. Stat. §44-2801 (1976).
2. Nebraska Hospital-Medical Liability Act, Neb. Rev. Stat. §44-2801 et. seq. (1992 Supp.).
3. Id.
4. Id.
5. Id.
6. Id.
7. Michael T. Wharton & Robert Dale Klein, Caps in the Hat Come Back: Revisiting Legislative Lids on Runaway Verdicts, For the Defense 10 (September 1993).
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11. Id.
12. Id. at 10-11.
13. Id. at 13.
14. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).
15. Id. at 107, 665.
16. Id. at 105-6, 664.
17. Id. at 110, 666-667.
18. Id. at 113, 668.
19. Id. at 116, 669.
20. Id. at 119, 670.
21. Justice Clinton concurred as to whether the Act grants the credit of the state in aid of an individual, association, or corporation, but dissented as to all other issues on the grounds of lack of justiciability.
22. NE Const. art. V, §2.
23. Nebraska Hospital-Medical Liability Act, Neb. Rev. Stat. §44-2834 (1992 supp.).
24. The Nebraska Hospital-Medical Liability Act Annual Report as of December 31, 1993.
25. Figures for "yearly average claim payments" reflect the average payment per claim out of the Excessive Liability Fund. Such figures do not include damages which a plaintiff may have additionally recovered from a physician's insurance coverage.
26. The Nebraska Hospital-Medical Liability Act Annual Report as of December 31, 1993.
27. St. Paul Fire and Marine Insurance Company Proposed physician and Surgeon Average Rates on an Annual Basis after July 1, 1992. (These Class 3 rates reflect the average premium paid by physicians and surgeons insured with St. Paul Fire and Marine Insurance Company. Individual premiums differ and are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage. The statistics listed are intended only to give a rough overview of rates nationwide.)
28. Id.

COMMENT

RE: "THE NEBRASKA HOSPITAL MEDICAL LIABILITY ACT: A SUCCESSFUL APPROACH TO MEDICAL MALPRACTICE CAPS", by Jane J. Kemper.

Ms. Kemper reviews the Nebraska Hospital-Medical Liability Act very thoroughly. There have been several attempts to overturn this statute since its inception. I have been present at, and testified at, several legislative committee hearings in opposition to these attempts. Some surprising testimony came forth at these hearings from members of the legal profession. One witness thought medical liability awards should be higher so that the victim of a bad medical outcome would be indemnified for his injury, lost wages, etc. Most of the time, disability insurance would be a more appropriate means for protecting oneself against this possibility. Certainly most physical disabilities which occur due to an illness or an accident are not due to a medical malpractice and should not be funded from the medical malpractice system.

Another witness was afraid to opt out of the system for fear that no physician would provide medical care for him. I told him that although most physicians would probably be willing to care for him, they would feel quite uncomfortable risking their homes, children's college funds, and other financial assets for that privilege. At that time, several years ago, the cost of an umbrella policy to cover such a patient in my speciality, neurosurgery, was approximately $7,000. If a patient chooses to opt out, I think he should be responsible for the entire insurance premium for such excess liability coverage since he is the only patient who would benefit from it. I do not know if such policies are available at the present time or what the premium would be.

Ms. Kemper does not know whether the Act has encouraged physicians to come to Nebraska to practice. When I was looking for a place to practice neurosurgery, I was influenced quite favorably by the Nebraska Hospital-Medical Liability Act and it was one of several major reasons why I located in Nebraska in 1979.

Finally, in a 1987 survey of neurosurgical practices nationwide, neurosurgical fees in Nebraska were among the lowest in the nation and often the absolute lowest in the nation. This convinces me that the Act has fulfilled the purpose of keeping physician fees at lower levels than in surrounding states.

Benjamin R. Gelber, M.D.

FRACTURE OF THE MONTH

Treatment of Chronic Tibial Osteomyelitis, Segmental Bone Loss, and Soft Tissue Defect by Bone Transplant

VERN J. PROCHASKA, M.D.
Orthopaedic Resident
Creighton-Nebraska Health Foundation

*J. URBAN LINDGREN, M.D.
Professor and Chief
Director of Orthopaedic Surgery
Creighton University School of Medicine

INTRODUCTION

The treatment of complex open fractures of the tibia remains an interesting and demanding challenge. High energy injuries often result in significant soft tissue and bony defect. Infection is also a frequent complication with rates up to 50% being reported for Grade III injuries.[1] Currently available techniques of free tissue transfer have greatly improved the surgeons ability to treat soft tissue loss, as well as infection. The treatment of segmental bone defects is more controversial. We report a case of chronic tibial osteomyelitis associated with a 6 cm bone defect and open draining sinus treated by the Ilizarov technique of bone transport. The transport was accomplished from distal to proximal using the ASIF external fixator.

CASE REPORT

A thirty-year-old male presented with a large sinus communicating with a 6 cm bony defect in the proximal tibia, secondary to an injury sustained approximately one-year earlier. His initial injury had been a comminuted Grade III-B open tibia fracture. The crush injury was caused by a motor vehicle accident in which his truck crashed into a retaining wall because of brake failure. Extrication from the vehicle required approximately 90 min. When he presented to the Emergency Department extensive soft tissue damage and the fracture shown in Figure 1 were noted.

Three months later he underwent a bone graft procedure and subsequently developed a draining sinus which cultured positive for Pseudomonas and methicillin resistant Staph Aureus. This was treated with parenteral antibiotics and multiple debridements. Figure 2 shows the resulting bone defect filled by a 5 cm antibiotic impregnated polymethylmethacrylate spacer. Seven months from the time of injury a latissimus dorsi free tissue transfer was done to cover the defect.

He presented to us one year from the date of the accident with a persistent draining sinus communicating with a cavity in the proximal tibia measuring roughly 6 cm by 4 cm x 3.5 cm. We applied an ASIF external fixator with a bone transport mechanism, and performed a percutaneous corticotomy at the distal tibia. Bone regeneration by callus distraction was then carried out at the rate of 1 mm per day. The infected cavity was packed open with dilute Betadine soaked gauze which was changed daily by the patient. The proximally transported

FIGURE 1
Radiograph of right lower leg. This extremely comminuted proximal third tibia fracture was associated with a severe crush injury.

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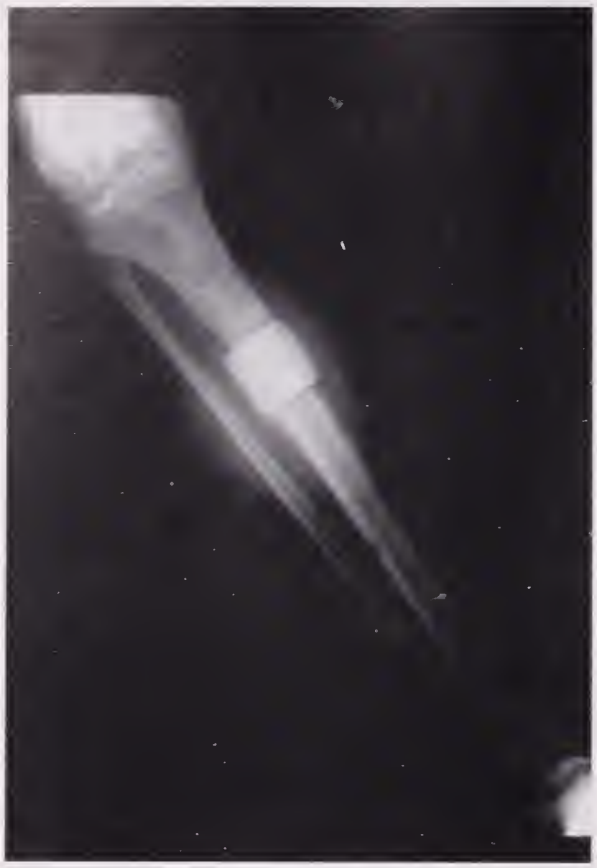

FIGURE 2
Radiograph of right leg after multiple debridements and treatment for pseudomonas and MRSA infection. Note: 6 cm defect filled with bone cement spacer.

FIGURE 3
Lateral radiograph demonstrating successful transportation and docking of bone segment with bone graft.

bone segment was successfully docked to the proximal tibial segment and bone grafted (Figure 3). At six months the cavity and sinus tract in the proximal tibia were closed completely. Progressive loading of the bone was accomplished by sequential release of the external fixator pins. The patient returned to the operating room six months after the corticotomy for the exchange of two loose fixator pins. The tibia was manually stressed at that time. The regenerated segment was clinically solid (Figure 4). Figure 5 shows the external fixator in place after completion of bone transport with all soft tissues well healed.

DISCUSSION

Severe open fractures of the long bones continue to present challenging problems in reconstruction and limb salvage. Until relatively recently few options were available for soft tissue coverage and bony reconstruction. Open fractures with associated arterial injury, Grade III-C, still carry a risk of amputation of 50% or more.[1] Free tissue transfers with microvascular technique have become accepted and standard procedures to cover large soft tissue defects.[2,3] The latissimus dorsi and rectus abdominis are the most frequently used muscles. The transfer may consist of muscle alone or the muscle and overlying skin. These tissues provide a healthy, well vascularized milieu for fracture healing, avoidance of infection, and further reconstruction.

The treatment of segmental bone loss of greater than 3 cm is more controversial, particularly in the presence of chronic infection. Numerous techniques have been used including massive cancellous autograft, Papineau grafts, allografts, prostheses, and vascularized bone grafts.[4,5] The technique of bone segment transport and elongation developed by Gavrill Illizarov of Russia has become more widely practiced over the pase few years.[6] This technique can be used to treat bone defects of almost any length.

This technique requires the application of an external fixator and division of the bone by a

FIGURE 4
AP and lateral radiograph demonstrating early consolidation of regenerated bone segment.

FIGURE 5
Clinical picture of right leg with external fixator in place. Bone transportation is complete and all soft tissue are healed. Note: latissimus dorsi flap proximally.

corticotomy. The divided bone segment is then slowly advanced into the defect. A delay of 7-10 days is usually allowed for early callus formation before the transport is begun.[7] Transport then proceeds at a rate of 1.0 mm per day. The patient accomplishes the transport himself by turning calibrated knobs on the fixator frame four times a day. The process of osteogenesis occurs by distraction of the callus. This regenerated segment rapidly remodels to cortical and medullary bone. On the compression side the segment is docked to the target fragment. The docking site is sometimes bone grafted to facilitate union.[8]

The tension of distraction not only promotes osteogenesis but also affects the soft tissues. Increased angiogenesis as well as increased thickness of the basal epidermal layer is seen. There is increased activity in the muscle tissue with formation of satellite cells and myoblasts. The activity of the entire soft tissue envelop is increased.[7] In addition, transport facilitates closure of soft tissue defects as the tissue is advanced with the bone segment.

Illizarov described the use of a circular frame with thin wires under tension transfixing the bone. Other types of external fixators have been used as well, including the unilateral ASIF fixator with half pins utilized in this case.[9,10] The unilateral frame is less bulky than the circular frame and may be more easily tolerated by the patient. Acceptance of the fixator is important as it may take a year or more for segmental transport and adequate consolidation.

Most series of tibial bone defects treated by the Illizarov technique utilize a proximal metaphyseal corticotomy and subsequent distal transport.[6,11] A distal corticotomy with proximal-ward transport is used less frequently because the capacity for osteogenesis in the diaphysis at the junction of the middle and distal one-third of the tibia are less favorable.[12] In cases of extremely large defects proximal and distal corticotomies can be used with simulataneous transport to lessen the time needed for osteogenesis.[7,13] Proximal-ward transport was necessary in the case presented be-

cause the defect was located just below the tibial tuberosity.

Complications are frequently encountered during the lengthy period of treatment required for this technique. One series of seventeen patients undergoing bone transport reported an average of 3.5 complications per patient.[6] Pin-site infection and loosening are the most common complications. Paresthesias have been reported during transport. Early consolidation of the regenerated segment may require a second corticotomy. Difficulty with docking of the transported segment to the target fragment can lead to nonunion. Flexion contractures in the adjacent joints can also occur.

SUMMARY

New methods of treatment have greatly improved the success of limb salvage in severe lower extremity trauma. We report the use of a microvascular free tissue transfer and distraction osteogenesis in the reconstruction of soft tissue and bone defects complicated by infection. Soft tissue coverage and bony stabilization by external fixation resulted in eradication of the infection. The external fixator also allowed bone transport and regeneration to overcome a bone defect of approximately 6 cm. Bone transportation can be accomplished in a distal to proximal direction if the situation necessitates it. These techniques are extremely versatile and useful in the treatment of bone and soft tissue defect.

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ALLIANCE

President's Letter

SALLY SEMM
President

"The world hates change yet it is the only thing that has brought progress. — "Charles Kettering.

"The Challenge of Change" is the theme I have chosen for this coming year. We are all faced with change on a daily basis, yet many times it does not come easily. Change is inevitable, whether we accept it is another matter.

The increase of violence in our country has altered our daily lives. It has effected where we go - or do not go - or whether we venture out alone. It has made us lock houses and cars. Many of us have taken self-defense classes or carry with us noise makers, mace, pepper gas, etc. We worry about victims of abusive relationships, schools have metal detectors, and our nation's government is working to pass a "crime bill".

The American Medical Association Alliance has focused on violence related issues as its health promotion project for the past few years. I have chosen to make teen violence the health promotion project in Nebraska for this coming year. It is my goal that every organized county will focus on teen violence and help bring awareness to this problem in Nebraska. Our youth are exposed to violent television, music, and movies on a daily basis. This is a problem all across Nebraska, not just in the large communities. In order to provide background information on this topic, the fall meeting will have a speaker to address this issue. Plan to attend the NMAA fall meeting on Thursday, October 13, to hear Jane Sebby, a TV producer from NETV speak about a program she has produced about "Teen Violence in Nebraska."

Another area of our medical lives that is evolving is, Health System Reform (Health Finance Reform?). It has made headlines for over two years. It will continue to be an issue and does not appear to be coming to closure. Many of our physician spouses have joined alliances, PPO's and are being expected to look at changes in management of patients. We as consumers want to be able to continue to choose our physician and not worry about treatment restrictions. Plan to attend the NMAA Legislative Day, Tuesday, March 7, 1995 and develop a clearer picture on legislative issues, especially in Nebraska. (Is there interest among the membership to sponsor a bill for this legislative session to mandate reporting of victims of domestic violence and elder abuse? If this interests you call Lynne Rustad at (402) 488-7615 or Sally Semm at (402) 421-2250.

Change is also effecting the membership of our organization. Membership, the only requirement for belonging to the AMAA, NMAA or a local organization is: you must be married to a physician. Look around the medical community. Do you know that approximately half of every medical school class is female? This means many males are eligible to join our association. Is your group adapting to meet the needs of this potential membership group? As our society has evolved over the past decade, and more women are entering the work force, many of our members have "gone back to work". This has effected the attendance and type of volunteer activities in many of our groups. Has your group accommodated for the needs of the working spouse?

The Nebraska Medical Association Alliance is also changing. Last year, President Barb Bohi encouraged every organized county to work on a statewide fund raiser in cooperation with the Make-A-Wish Foundation. To my knowledge, we have never done a statewide project before. It turned out to be financially successful and rewarding for those who participated.

Continuing with this proactive approach, the NMAA Executive Board held a video teleconference August 3, which linked Scottsbluff, Omaha & Lincoln together. This successful change saved time and travel money. This fall in addition to holding a board meeting, we are going to also provide two informative speakers. It is my hope you will be able to attend and increase your knowledge of American Medical Association Health Projects, as well as teen violence. Mrs. Ann Wrenn, Field Director for

the AMAA will present the information on Health Projects. It will also be a great opportunity to renew old friendships and make new ones.

The last change I would like to mention is difficult for me to believe as a positive change. Donna Stone (Lancaster) has "retired" from the American Medical Association Alliance board. She has served for the past two years as a national AMA-ERF committee member. This past year she also served on the national nominating committee. Her commitment to our organization at the local, state and national level has been tremendous. We will miss her as a dedicated, hard working representative, but certainly hope she will continue to be active at the state and local level. Thank you Donna!

One aspect of our organization that does not change is the visits to the counties by the State Presidents. We enjoy visits to local county meetings and look forward to the one on one contact with each of you!

Oh yes! *The Challenge of Change.*

ASK A LAWYER

CHARLES M. PALLESEN, Esq.
1900 FirsTier Bank Building
Lincoln, NE 68508

1. What is the purpose of the Health Care Facility-Provider Cooperation Act passed as a part of LB 1223 by the 1994 Nebraska Legislature?

This Act is designed to encourage cooperative agreements between providers and health care facilities to better serve patients and make more efficient use of health care resources. A Certificate of Public Advantage and immunity from antitrust prosecution are incentives for taking the necessary steps to have a cooperative agreement approved by the Department of Health. This provision was part of a larger bill designed to improve medical care and it became effective in April of 1994. Seeking the Certificate of Public Advantage is voluntary on the part of the health care provider. The Department of Health will consider whether one or more of the following benefits will result.

a. Enhanced facility and provider care;
b. Keeping facilities in proximity to users;
c. Gains in cost efficiency;
d. Improvements in utilization of facility resources;
e. No duplication of facility resources;
f. Preserving competition for the services involved; and
g. Mitigation of adverse environmental impact or enhancement of positive environmental impact.

Disadvantages to be evaluated by the Department will include:

a. Impact on HMOs, PPOs, etc., to negotiate;
b. Reduction in competition;
c. Adverse impact on services to patients; and
d. Alternatives less restrictive to competition.

2. Of what value is this Act to physicians and how does it relate to the federal antitrust laws?

This Act is potentially of great value to hospitals, doctors, nurses and anyone who is a part of negotiations for a cooperative agreement. According to the author of the bill, it is designed "to facilitate and enable people to do things they would like to do but, currently, with federal antitrust have been barred from doing." Sen. Withem, floor debate on amendment to LB 1223, April 5, 1994.

Immunity is accomplished and cooperation encouraged by the use of a federal exemption from antitrust action. An exemption is available if the "state intervenes and actively regulates the activity and oversees the activity," according to Withem. Applications of this test will be important to see if the federal antitrust authorities accept this action by the State. Clear and convincing evidence must be presented to the Department of Health that the cooperation is in the public interest before a Certificate of Public Advantage is issued. The Department of Health can review the cooperative agreement at any time and take away the Certificate of Public Advantage if the burden upon competition does not outweigh public benefits. It may consult with the Nebraska Attorney General as to its decision. The Department of Health Attorney General as to its decision. The Department of Health wants to ensure that the entities involved work as a cohesive unit to provide the least costly, highest quality services available.

***

"Ask a Lawyer" is a feature of the Nebraska Medical Journal. If you have a legal question of general interest, please write the **Nebraska Medical Journal**. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen with the assistance of University of Minnesota Law School student Jason Krieser of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

WELCOME NEW MEMBERS

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3016 W. Faidley
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COMING MEETINGS

CREIGHTON UNIVERSITY

OCTOBER 19, 1994 — Distinguished Lecture Series, William J. Hoskins, M.D.

NOVEMBER 9, 1994 — Distinguished Lecture Series - Herman I. Libshitz, M.D., BTNRH Auditorium.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite 2130, Omaha, NE 68131.

MAYO FOUNDATION

FEBRUARY 1-8, 1995 — Update in Clinical Neurophysiology, Mayo Clinic, Rochester, MN.

FEBRUARY 4-8, 1995 — Selected Topics In Internal Medicine, Silverado Resort, Napa Valley, CA.

FEBRUARY 9-11, 1995 — Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management, Silverado Resort, Napa Valley, CA.

MARCH 24-26, 1995 — Advances in Clinical Anesthesiology, Silverado Resort, Napa Valley, CA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

APRIL 27-30, 1995— Annual Session, Cornhusker Hotel, Lincoln.

SEPTEMBER 21-23, 1995 — Fall Session, Cornhusker Hotel, Lincoln

APRIL 25-28, 1996 — Annual Session, Omaha Marriott Hotel.

SEPTEMBER 12-14, 1996 — Fall Session, Cornhusker Hotel, Lincoln.

UNIVERSITY OF NEBRASKA MEDICAL CENTER EMERGENCY MEDICAL SERVICES

OCTOBER 20-21, 1994, THURSDAY-FRIDAY — Advanced Cardiac Life Support (ACLS) - Provider. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA CAtegory I, 14.5 Hours Prescribed Hours AAFP. Fee: $195.

OCTOBER 24-25, 1994, MONDAY-TUESDAY — Advanced Trauma Life Support (ATLS). University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians. Credit: 17.0 Hours AMA Category I, 16.0 Prescribed Hours AAFP, 17.9 Hours ACEP Category I. Fee: $550.

OCTOBER 31 - NOVEMBER 1, 1994, MONDAY-TUESDAY — Trauma Nurse Core Course (TNCC), University of Nebraska Medical Center Campus, Omaha, Nebraska, Target Audience - Nurses. Credit: 18 CECH's of BCEN's Category of Clinical. Fee: $210 - Non-ENA Members, $175 - ENA Members.

NOVEMBER 7-8, 1994, MONDAY-TUESDAY — Advanced Cardiac Life Support (ACLS) - Provider, University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses PA's, Allied Health Professionals. Credit: 14.5 Hours AMA Category I, 14.5 Prescribed Hours AAFP. Fee: $195.

DECEMBER 1, 1994, THURSDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.

DECEMBER 2, 1994, FRIDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

DECEMBER 2, 1994, FRIDAY — Pediatric Advanced Life Support (PALS) Instructor, Univer-

sity of Nebraska Medical Center Campus, Omaha, Nebraska. Credit: 4 Hours AMA Category I, 4 Hours Prescribed Hours AAFP. Fee $50.

For further information: Contact Cindy Hanssen, University of Nebraska Medical Center, Center for Continuing Education, 600 So 42nd Street, Omaha, Nebraska 68198-5651. Call (402) 559-5919 or use our toll free MD ADVANTAGE NUMBER AND ASK FOR CONTINUING EDUCATION (1-(800)652-1095 NATIONWIDE. FAX NUMBER (402) 559-5915.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

OCTOBER 19, 1994, WEDNESDAY — Advanced in Acid Related Diseases, Omaha Marriott, Omaha, Nebraska. Target Audience: Primary Care Physicians.

OCTOBER 22, 1994 — Transfusion Medicine, University of Nebraska Medical Center. Target Audience: Surgeons and Anesthesiologists.

NOVEMBER 12, 1994, SATURDAY— Evaluation and Management of the Swollen Extremity, UNMC, College of Nursing, Omaha, Nebraska. Target Audience: Primary Care Physicians and Nurses.

DECEMBER 1-3, 1994, THURSDAY-SATURDAY — Obstetrics and Gynecology Conference, Bally's, Las Vegas, Nevada. Target Audience: Primary Care Physicians, Obstetricians and Gynecologists. Fee: $275.

MARCH 5-10, 1995, SUNDAY-FRIDAY — 15th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MARCH 27-APRIL 7, 1995, 11 DAYS — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

APRIL 24-MAY 5, 1995, 11 DAYS — Family Practice Review , Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

JUNE 2-3, 1995, MONDAY-TUESDAY— Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

JUNE 9-10, 1995, FRIDAY-SATURDAY — 3rd Annual Diagnostic Dilemmas in Women's Health Care, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Physician Assistants. Fee: $200.

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NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

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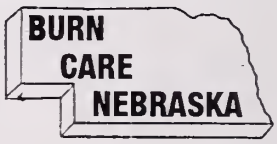

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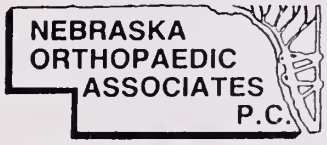

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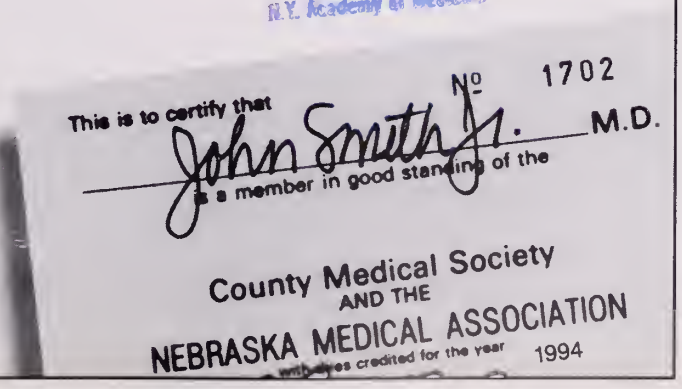

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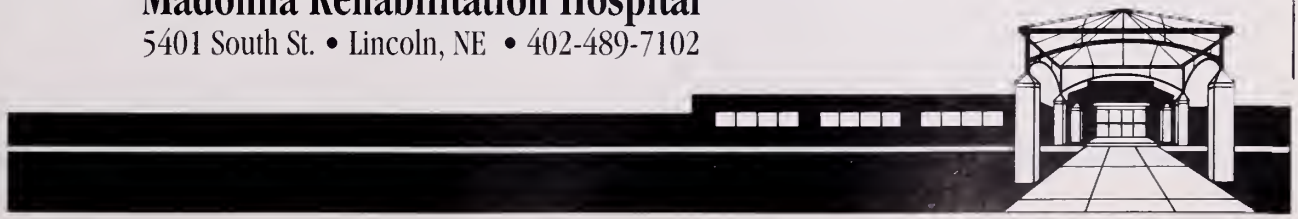

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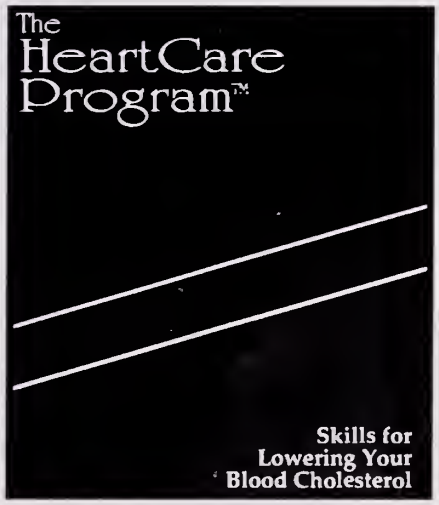

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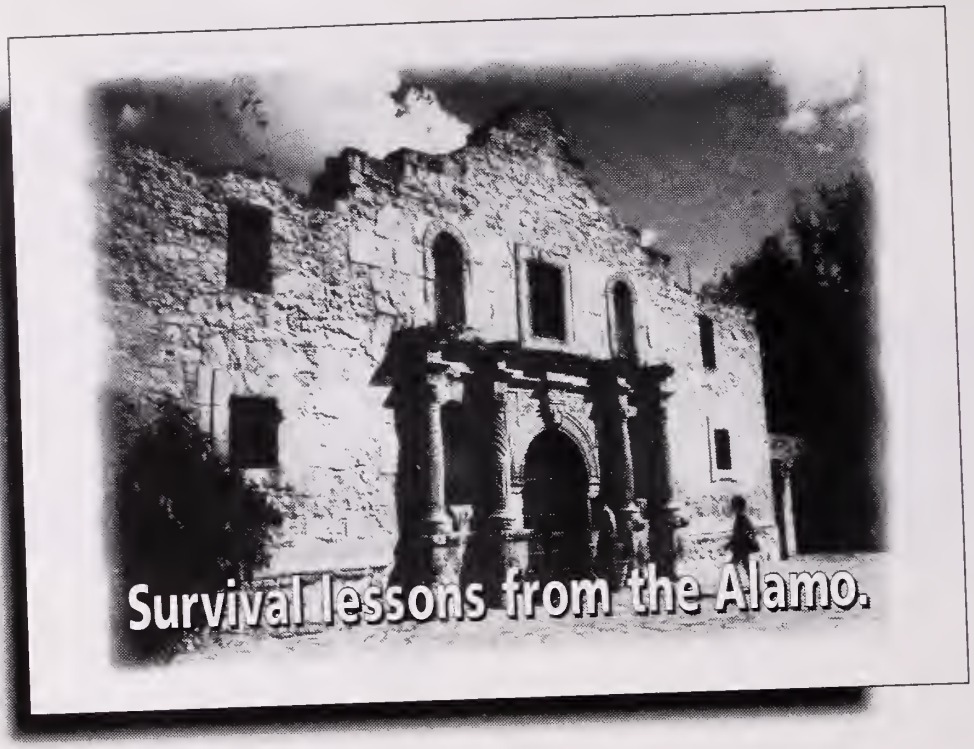

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PRESIDENT'S PAGE

Physician Discipline - Concerns and Misconceptions

FREDERICK F. PAUSTIAN, M.D.

During the course of meetings over the past five months and in multiple private conversations, concerns have been expressed to me by physicians regarding the State of Nebraska's physician disciplinary process. Most of these concerns relate to the severe emotional and potential negative financial impact of disciplinary proceedings before the validity of the charges have been determined. A very informative segment of the Cline Williams/Nebraska Medical Association Physician and Staff Preventive Law Seminar, September 16, 1994, entitled "Physician Discipline in Nebraska", was discussed by attorney Charles M. Pallesen. Included in the handout were two documents which are of importance to Nebraska physicians: - Table 1, LB 1223-Mandatory Reporting Requirements and Flow Chart 1, Nebraska Bureau of Examining Boards (N.B.E.B.), Department of Health Disciplinary Process. The former was recently distributed to all physicians within the state during the application process for re-licensure. It specifies what types of physician alleged improper conduct and performance and what kinds of adverse actions against physicians must be reported

Frederick F. Paustian, M.D.

TABLE I

LAWS 1994 LB 1223 - MANDATORY REPORTING REQUIREMENTS

WHAT TO REPORT	WHO IS TO REPORT
1. Practice without License.	All Professionals
2. Gross Incompetence. 3. Pattern of Negligent Conduct. 4. Unprofessional Conduct. 5. Practice while Impaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability. 6. Violations of Other Regulatory Provisions of the Profession.	All Professionals report Others of the SAME Profession.
7. Gross Incompetence. 8. Practice while Inpaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability.	All Professionals report Others of a DIFFERENT Profession
9. Loss or Voluntary Limitation of Privileges 10. Resignation from Staff 11. Loss of Employment 12. Licensure Denial 13. Loss of Membership in Professional Organization (Due to Alleged Incompetence, Negligence, Unethical or Unprofessional Conduct, or Physical, Mental, or Chemical Impairment) 14. Adverse Action pertaining to Professional Liability Coverage. 15. Licensure Discipline/Settlement/Voluntary Surrender/Limitation in another State or Jurisdiction. 16. Conviction of Felony or Misdemeanor in this or any other State or Jurisdiction.	All Professionals --- Self-Reporting
17. Payments made due to Adverse Judgement, Settlement, or Award 18. Adverse Action affecting privileges or membership.	Health Facilities, Peer Review Organizations, and Professional Associations
19. Violation of Regulatory Provisions Governing a given Profession 20. Payments made due to Adverse Judgment, Settlement, or Award. 21. Adverse Action affecting coverage.	Insurers
22. Convictions of Felony or Misdemeanor involving use, sale, distribution, administration, or dispensing Controlled Substances.	Clerk of County or District Court

Report to: Bureau of Examining Boards
P.O. Box 95007
301 Centennial Mall South (402) 471-2115
Lincoln, NE 68509-5007

to the Department of Health's N.B.E.B. The Flow Chart has had very limited exposure. It identifies the sequence of events which may occur during the assessment of improper conduct and performance charges, but does not include when such charges become public information.

As a consequence of recent media attention and, questionably, the passage of LB 1223, there has been a significant increase in the reporting of allegations of inappropriate health provider practice (especially physicians, nurses, and pharmacists), which is causing major concern among all health care professionals. The Nebraska Medical Association recognizes the need for public disclosure and has been strongly supportive of physician discipline but only when the allegations are substantiated after appropriate hearings with due process. Many times the complaints are unjustified and such charged professionals suffer seemingly unnecessary emotional trauma and financial loss (legal fees, practice revenue) from public disclosure of the allegations before appropriate hearings with due process have been conducted. A restatement of reporting requirements and a review of the disciplinary process, is therefore, in order so that all physicians may understand the sequence of the activity and the level of review which has been conducted before any allegation becomes a matter of public record.

A request was made to the N.B.E.B. for a narrative description of the disciplinary process. A document titled "Brief Summary of the Disciplinary Process" was received to which frequent reference will be made as well as to the flow chart. A copy of the summary may be obtained from the offices of the Nebraska Medical Association.

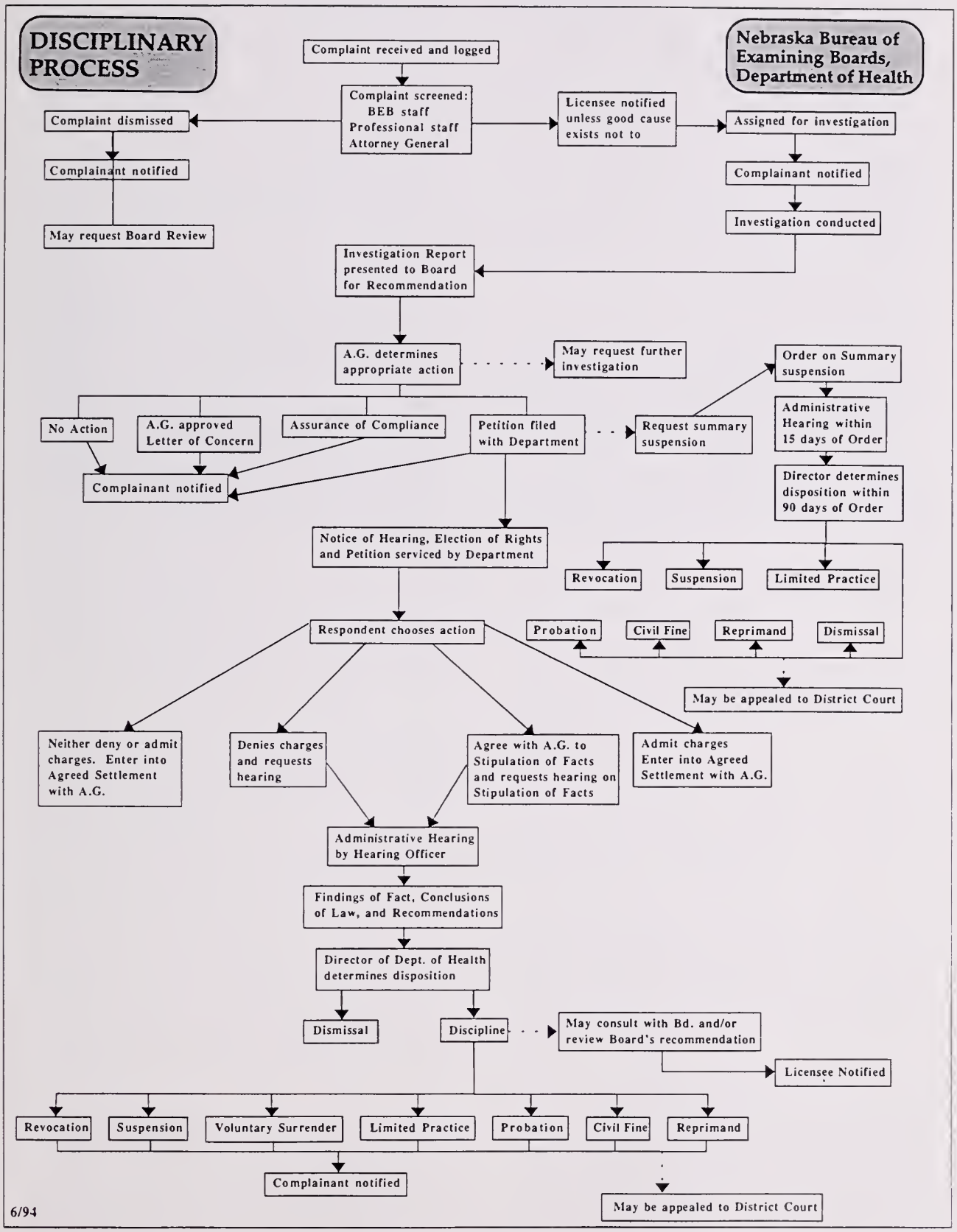
When a complaint concerning a physician is received by the N.B.E.B., it is screened by a committee consisting of a member of the Medical Board, an Assistant Attorney General and a staff member of the N.B.E.B. If it is determined the complaint warrants investigation, the allegation is assigned to one of the investigators for the Board and a Board member serves as an investigative consultant. When the investigation is deemed complete the results are presented to the entire Medical Board in closed session for action. The Board has two options: direct the investigator to conduct further inquiry in specified areas or if the investigation is deemed to be complete, make a recommendation to the Attorney General (A.G.). Among the recommendations which the Board may make to the A.G. are:

1. No action (<u>not</u> a matter of public record)
2. A Letter of Concern which is not considered a disciplinary action, but <u>is</u> a matter of public record.
3. An Assurance of Compliance which is not considered a disciplinary action, but <u>is</u> a matter of public record.
4. A Petition be filed because of the seriousness of the allegation and sufficient substantiation by the preliminary investigation, which <u>becomes</u> a public document.
5. If the violation is of such a nature that there is potential for public harm, the Board may recommend a Temporary Suspension of Licensure to the A.G. who forwards the recommendation to the Director of the Department of Health. The Director must issue an order for temporary suspension. The temporary suspension <u>is</u> a matter of public record.

The Letter of Concern states the allegation and that, if it were proven, it would be a violation of the statutes and disciplinary action may be taken. The Assurance of Compliance delineates the alleged misconduct and the corrective steps to be taken to cease and desist the improper activity, and if there is a failure of compliance, disciplinary action may be taken. A major question to be raised by our Association and studied by all concerned is: if these two alternatives are not disciplinary actions, and there has been no hearing with due process, why must they be a matter of public record? The remainder of the process as depicted in the flow chart is self explanatory, all of which <u>is</u> a matter of public record.

There are two important points concerning the process which warrant emphasis. The first is that there is a screening process and investigation and only if there is significant support of the allegation by the investigation, as determined by the Medical Board, does the problem become a matter of public record. The second point is that, although an investigation is conducted which is supportive of the allegation, there is no due process hearing before the problem becomes a matter of public record. While such charges can be extremely damaging to the defending physician; right or wrong, the process and actions which become a matter of public record are somewhat similar to the sequence of events which take place in other legal proceedings. However, the <u>need</u> for public disclosure before the substantiation of guilt is open to serious question. This aspect of the process is expected to receive considerable attention during the Department of Health's forthcoming comprehensive review of Nebraska's uniform licensing laws.

FLOW CHART I


DISCIPLINARY PROCESS
Nebraska Bureau of Examining Boards, Department of Health
Complaint received and logged
Complaint screened: BEB staff Professional staff Attorney General
Complaint dismissed
Complainant notified
May request Board Review
Licensee notified unless good cause exists not to
Assigned for investigation
Complainant notified
Investigation conducted
Investigation Report presented to Board for Recommendation
A.G. determines appropriate action
May request further investigation
No Action
A.G. approved Letter of Concern
Assurance of Compliance
Petition filed with Department
Request summary suspension
Order on Summary suspension
Administrative Hearing within 15 days of Order
Director determines disposition within 90 days of Order
Complainant notified
Notice of Hearing, Election of Rights and Petition serviced by Department
Revocation
Suspension
Limited Practice
Probation
Civil Fine
Reprimand
Dismissal
Respondent chooses action
May be appealed to District Court
Neither deny or admit charges. Enter into Agreed Settlement with A.G.
Denies charges and requests hearing
Agree with A.G. to Stipulation of Facts and requests hearing on Stipulation of Facts
Admit charges Enter into Agreed Settlement with A.G.
Administrative Hearing by Hearing Officer
Findings of Fact, Conclusions of Law, and Recommendations
Director of Dept. of Health determines disposition
Dismissal
Discipline
May consult with Bd. and/or review Board's recommendation
Licensee Notified
Revocation
Suspension
Voluntary Surrender
Limited Practice
Probation
Civil Fine
Reprimand
Complainant notified
May be appealed to District Court
6/94

Even though physician disciplinary proceedings are not conducted in a court of law, the investigation leading to the proceedings are directed toward determining the validity of the charges, not exonerating the physician. Therefore, any physician confronted with such an investigation must immediately seek legal counsel and not submit to inquiry in the absence of such counsel. All physicians should read carefully the recently distributed article by the NMA, "When Silence Is Especially Golden", by attorneys Curry, Erickson, and Sederstrom, Nebraska Health Law Digest, Spring Summer, 1994, which succinctly described the gravity of the investigation and disciplinary proceedings and the critical importance of retaining counsel as soon as it is evident charges have been filed.

An element of the disciplinary proceedings which is generally not appreciated by health professionals is the cost of defense of allegations of inappropriate conduct or practice together with the potential for the cost of the entire action to be charged to the defendant in the event of an adverse decision. Our current physician professional liability insurance does not cover attorney fees, disciplinary proceedings cost and judgement imposing civil penalties. The defense of unwarranted allegations by vindictive patients and/or jealous colleagues has been known to exceed many hundreds of dollars in legal fees. Literally, physicians are "going bare" as regards insurance coverage for defense against such charges and the cost of the proceedings. Because of the increasing potential for such action, it is the intent of the Nebraska Medical Association to review with professional liability insurance carriers the provision of, and market for insurance options to cover the cost and penalties associated with disciplinary proceedings.

It is most important for all the physicians of the State of Nebraska to fully understand the conditions which must be reported concerning physician discipline under Nebraska state law and by whom. In addition it is highly advisable to become familiar with the process by which physician disciplinary action is conducted and the effect of such action. Obviously, the best defense against charges of inappropriate conduct and provision of medical service is for each physician to consistently practice in an exemplary manner.

GUEST EDITORIAL

Epinephrine for Anaphylaxis

CLAUDE A. FRAZIER, M.D.
Asheville, North Carolina

In my struggle as a lone crusader for a model bill to allow trained laymen to administer epinephrine to people having anaphylactic reactions, I appeared before the FDA and the NIH Open Consensus Panel. I appeared before the AMA Board of Trustees at the request of my Senator from North Carolina. I began my talk, "I have some bad news for you and some good news. The bad news is that any one of you can walk out of this hotel and be strung and die in five minutes even if you have never had a previous reaction. The good news is that if a trained layman, such as a policeman, were allowed to give epinephrine, you would be saved."

After 10 years, many letters and frequent phone calls, the American Medical Association decided to prepare a model bill. This allows trained persons to administer epinephrine to a person suffering from a severe reaction to an insect sting. Death can occur in five to ten minutes and in most cases, this is insufficient time to get to a doctor or to a hospital and the person can die.

For 20 years, I have been a Lone Crusader in educating laymen, especially teachers, on the importance of diagnosis of an anaphylactic reaction due to insect stings and immediate treatment with an insect sting kit. Children playing at recess are very likely to get stung. If one has an anaphylactic reaction there usually is not time to get to a hospital or to a physician.

I feel so deeply about this life-saving endeavor that I have done the work to date with no help financially. I have also been able to get the Army, Navy, Air Force, Marines, and Park Services to include insect sting kits containing epinephrine in their medical kits.

There are many needless deaths because of the ignorance of laymen. A nurse who was a patient of mine told me about her brother who was cutting a hedge around a doctor's home. He was stung and had an anaphylactic reaction. He went inside and called for an ambulance. The doctor didn't know what to do, the EMT workers didn't know what to do. He died. There are many needless deaths because of the ignorance in laymen.

Some high-school football players who die suddenly have their deaths in most cases attributed to heart attack. Investigations of some of these deaths have disclosed other players had heard the victim say that he had been stung. And the findings are consistent with anaphylaxis.

Sometimes a physician may be ignorant of proper management and administer antihistamines or steroids. For example, a young boy received multiple stings and was rushed to a nearby hospital. The physician wasn't sure of the proper treatment and sent him to another hospital. At neither hospital was the boy given epinephrine.

Early treatment with epinephrine after an anaphylactic reaction can be life saving. Even after this injection, the patient should always go to a hospital.

Persons in charge of others, especially outdoors, such as schoolteachers, coaches, school nurses, tennis or golf pros, and forest rangers should be legally allowed to administer life-saving epinephrine.

The American Academy of Allergy and the American College of Allergy have passed special resolutions supporting this. Also, the past presidents of the American Academy of Family Physicians and of the American Academy of Pediatrics have written letters of support.

Only 15 states have passed this law. To be legal in the administration of epinephrine, a layman must receive training by a physician. I have prepared a training program complete with slides that I can furnish at cost to physicians wishing to conduct training programs in states that have passed the law.

Recently, a lady from Florida called to tell me of her handicapped son who was severely allergic to bees. He had had a reaction and was given an insect sting kit. She explained this to the boy's bus driver. The driver told her that due to state law, he was unable to give any type injection or medication. The mother and I have been working to have Florida change this so even bus drivers can legally administer epinephrine. She asked me to appear before the Senate Subcommittee of Health Care and Health Rehabilitations Services.

In Asheville, a mother called me to report that her son, who also had a previous reaction, was fishing one day when stung and died. She called because she knew of the work I was doing and told me the doctor had given the boy antihistamines to take if stung again, and asked if this was right. I knew it was too late to save the boy's life, so I didn't say anything.

Dr. Donald Cook of the American Academy of Pediatrics and School Health Committee wrote in a letter to the chairman of the Communications and Public Information Committee of the American Academy of Pediatrics, "The problem is this: (1) very few school people, parents or physicians are aware of the potential seriousness of the problem. (2) If they were aware, they wouldn't know what to do. (3) If they did know what to do they would be afraid to do it or (4) Their school administrators would prevent them from doing it for fear of a law suit.

It is legal for a person having an insect sting reaction to obtain an insect sting kit but fatal reactions can and do occur in persons with no previous history of reaction. It still amazes me when I hear at lectures I give of a person who has had a severe reaction previously and was only given an antihistamine to carry. This will not save lives.

People do die from anaphylactic shock reactions to insect stings and I am convinced that there are many more not documented because of misdiagnosis.

ORIGINAL ARTICLE

Health Care Maintenance for the Asymptomatic HIV Infected Individual

JANE ROCCAFORTE, M.D.
Internal Medicine Associates, P.C.,
Omaha, Nebraska

THE Nebraska Department of Health has been gathering data on AIDS since the first case was reported in 1983. At the completion of 1993, 491 men, women, and children in Nebraska had been diagnosed with this disease. Certainly, AIDS is not limited to Lancaster and Douglas Counties. For example, since January of 1983, 11 persons have been diagnosed with AIDS in the Panhandle and 9 in the West Central region of Nebraska (See figure). It is important that primary care practitioners throughout our state be familiar with HIV infection and disease. This article will focus on a common circumstance: the initial evaluation of the asymptomatic HIV infected individual.

After a diagnosis of HIV infection is confirmed by serologic testing, symptom review and physical examination should be performed. Specific questions should be asked about weight loss, fever, diaphoresis, cough, dyspnea, diarrhea, history of hepatitis, history of sexually transmitted disease, and history of skin conditions including Herpes zoster. A general physical examination with attention to the oral cavity, skin, and node bearing areas is also productive.

Certain tests need to be done to further investigate the health status of the HIV infected individual. These tests allow the physician to diagnose unsuspected concurrent disease. Also, knowledge of baseline test results can be useful in the future when symptoms do develop.

These tests include:

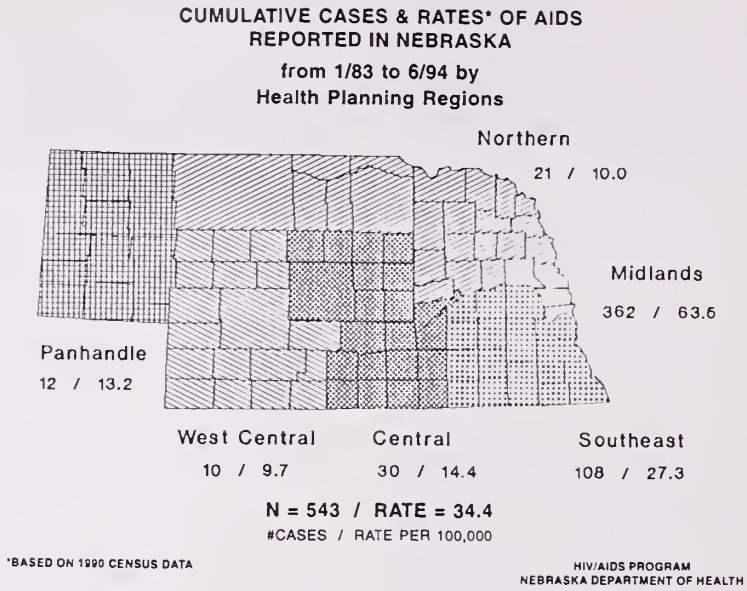
1. CBC with differential and platelet count.
2. Electrolytes, BUN, creatinine.
3. Liver function tests.
4. CD4 (helper) and CD8 (suppressor), Lymphocyte count (percentages and ratio).
5. Hepatitis B surface antigen (HBsAG) and Hepatitis B surface antibody (HBsAB).
6. VDRL or equivalent serologic test for syphilis.
7. Chest x-ray (PA and lateral).
8. PPD with control.

While the sedimentation rate, P24 antigen, beta 2 microglobulin and other tests have been advocated by various investigators to predict progression of HIV infection to end stage (AIDS) the absolute CD4 lymphocyte count remains the most powerful prognostic tool.

Knowing the initial CD4 count helps the physician to decide when to initiate Zidovudine (AZT) therapy. If the CD4 counts is greater than 500 cells per cubic mm., a repeat CD4 count as well as a CBC and physical examination should be done every 6 months. If the CD4 count approaches 500 cells per cubic mm. or drops quickly, the patient should be examined and the CBC as well as CD4 should be repeated every 3 months.

If a CD4 count is approximately 500 cells per cubic mm. or less, the physician should consider initiation of Zidovudine therapy at a dose of 500 mg. per day (100 mg. orally every 4 hours while awake) or 200 mg. 3 times a day. Once the individual is on Zidovudine the CD4 count can be checked every 3 months until it reaches 200 to 250 cells per cubic mm. At this point, prophylaxis against Pneumocystic carinii pneumonia can be initiated. This can be accomplished by twice daily trimethoprim-sulfamethoxazole double strength tablets every Monday, Wednesday, and Friday or every weekend. Second-line therapy consists of once monthly aerosolized Pentamidine at a dose of 300 mg. Finally, Dapsone, at a daily oral dose of 100 mg. provides alternative chemoprophylaxis for the person who is allergic to sulfa. Patients on AZT and Sulfa therapy should have CBC's monitored frequently to screen for hematologic toxicity.

*Address correspondence and reprint request to: Dr. Jane Roccaforte, Internal Medicine Associates, P.C., Omaha, Nebraska, 402/552-2917 or Lesa Rastede-VanderVeen, Nebraska Department of Health Ryan White Coordinator at (402) 471-2937.



If both the Hepatitis B surface antigen and Hepatitis B surface antibody are negative, the patient is a candidate for Hepatitis B vaccination. If the Hepatitis B surface antigen is positive, the vaccine is of no benefit, and the patient is infectious to others. If the Hepatitis B surface antibody is positive, the patient has evidence of prior disease and is no longer infectious to others. The vaccine would be of no benefit to that patient.

If the VDRL is positive, a confirmatory test, such as the FTA-ABS should be performed. A VDRL titer should be done if the confirmatory test is positive. Infectious diseases such as syphilis can be more aggressive in the HIV infected individual and should be treated promptly.

A chest x-ray is necessary in the assessment of a positive PPD. A chest x-ray is also useful for comparison purposes when and if the patient exhibits pulmonary symptoms. In an HIV positive person, a PPD of greater than or equal to 5 mm. of induration is considered significant. In such a patient, if no evidence of active tuberculosis exists, prophylactic INH is indicated at a dose of 300 mg. daily for 6 to 12 months.

HIV positive individuals are candidates for immunization, including a single pneumococcal vaccination and yearly influenza vaccination given in October or November. A series of 4 polio vaccines should be given to patients and household contacts not previously immunized. Use only inactivated vaccine. Physicians caring for patients living with or frequently associating with younger children should alert the child's physician to avoid immunizing with oral polio vaccine as the HIV infected patient could be put at risk for polio.

One dose of Haemophilus influenza type b vaccine may be given, although the efficacy in this patient population is uncertain. A diphtheria and tetanus vaccination should be given every 10 years, as it would be to the general patient population. A single measles vaccine may be indicated in patients born after 1956 who lack protective titers. The efficacy is uncertain, but use of this live vaccine appears to be safe.

Finally, HIV infected patients may also benefit from nutritional evaluation and recommendations. A young adult with HIV infection may have little appreciation of this important aspect of general health maintenance.

The initial evaluation of an HIV infected individual represents a significant investment in time and energy for both the patient and the primary care practitioner. However, these "healthcare maintenance" endeavors will stand the patient in good stead for the future.

For more information, call or write the
Nebraska Department of Health
Division of Disease Control
301 Centennial Mall South
Lincoln, Nebraska 68509-5007
(402) 471-2937
or
CDC National AIDS Hotline
1-800-342-AIDS (2437)

ORIGINAL ARTICLE

Gastrointestinal Motility Tests - When to Call the Motility Lab?

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INTRODUCTION

SEVERAL recent developments have led the study of gastrointestinal motility and its disorders to assume a more prominent status in clinical medicine. These include a tremendous blossoming of our understanding of gastrointestinal motor physiology, a profusion of new technologies which now permit a more accurate assessment of motor events and finally, and perhaps of greatest importance to the practicing clinician, the arrival of a number of therapeutic agents which offer promise in the therapy of symptomatic dysmotility. This review will attempt to provide an overview of upper gastrointestinal motility disorders and will suggest an approach to the investigation of suspected dysmotility. Table I lists the most common clinical disorders which are either known or suspected to be related to intestinal motor dysfunction - an approach to the evaluation of each of these common syndromes will briefly outlined.

Dysphagia (Figure 1)

Dysphagia can first be divided into obstructive and non-obstructive varieties. Obstructive or "mechanical" causes such as peptic stricture, esophageal cancer and Schatzki's ring are indeed quite common - here endoscopy assumes a primary role. For the purposes of this review we will assume that organic causes have been excluded. In terms of both pathophysiology and diagnostic evaluation, functional, or "non-obstructive" dysphagia can be conveniently divided into two general categories, namely oropharyngeal and esophageal.

Among patients with oropharyngeal dysphagia, most will have either an underlying central nervous system disorder such as cerebrovascular disease, Parkinson's Disease, muscular dystrophy, or a structural abnormality such as a tumor of the oropharynx.[1] For patients with esophageal dysphagia, in contrast, primary disorders of the esophagus itself such as gastroesophageal reflux and motor disorders are more common.

Important steps in the evaluation of a patient with oropharyngeal dysphagia include a detailed cine- or video-esophagram as well as an ENT and/or neurological evaluation, as indicated.[2] Because of the rapidity with which oropharyngeal swallowing events take place, the relative asymmetry of the upper esoph-

TABLE 1

CLINICAL MOTILITY DISORDERS

Dysphagia
Gastro-esophageal reflux disease (GERD)
Non-cardiac chest pain

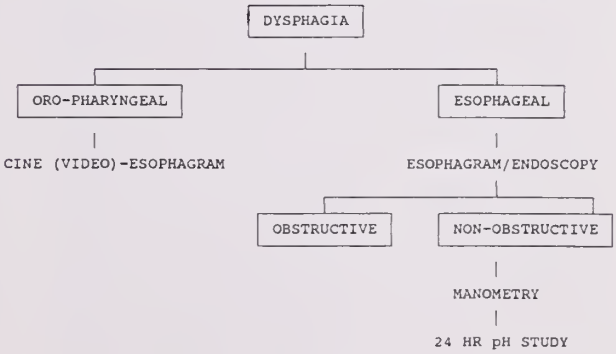
Gastroparesis
Non-ulcer dyspepsia

Ileus
Intestinal pseudo-obstruction

Oglivie's syndrome
Constipation
Incontinence

Irritable bowel syndrome

Figure 1
An algorithm for the evaluation of dysphagia.



*Reprints request and correspondence to: Eamonn M.M. Quigley, M.D., Section of Gastroenterology and Hepatology, University of Nebraska Medical Center, 600 S. 42nd Street, Omaha, NE 68198-2000.

ageal sphincter and poor patient acceptance of perfused manometric systems in the oropharynx, standard manometry is an inferior diagnostic tool in this circumstance. High fidelity solid-state microtransducer systems, available in some specialized units, are required for the accurate registration of the rapid intraluminal pressure changes which occur in this area. These systems must also ensure sustained contact with the upper sphincter as it moves during swallowing. In most institutions, a video- or cine-esophogram is the most important test. Important components of the evaluation include an assessment of cricopharyngeal function, the detection of tracheal and naso-pharyngeal aspiration and a determination as to whether retraining may be possible. In patients with severe oro-pharyngeal dysphagia complicated by aspiration and malnutrition percutaneous gastrostomy feeding may be indicated.

Among patients with non-obstructive esophageal dysphagia, primary motor disorders such as achalasia and diffuse esophageal spasm are important possibilities. Here manometry assumes an important place in the diagnostic work-up. If manometry proves normal or demonstrates only non-specific motor abnormalities, gastroesophageal reflux disease should be considered as it is increasingly appreciated that reflux disease is a not uncommon cause of functional dysphagia. When endoscopy fails to reveal evidence of esophagitis and manometry proves non-diagnostic, I would strongly recommend therefore, proceeding to a 24 hour pH study.

Gastroesophageal Reflux Disease

In contrast to other "acid-peptic disorders," such as duodenal and gastric ulceration, gastroesophageal reflux disease (GERD) encompasses a spectrum of clinical entities which range from reflux, which we now know to be truly physiological at one end, to chronic reflux-related esophagitis complicated by Barrett's epithelium and stricture formation at the other. In between these two extremes lie most patients seen in clinical practice: those individuals with reflux-type symptoms without endoscopically visible esophagitis and those with uncomplicated esophagitis. Atypical presentations of reflux disease are being increasingly recognized and include dysphagia, non-cardiac chest pain (to be described below), chronic cough, laryngitis and obstructive airways disease.[3-5] "Endoscopy-negative" reflux disease appears to be particularly prevalent among these latter groups. In many instances therefore, the diagnosis of reflux and its incrimination as a cause of a patient's symptom(s) depends on the separation of "normal" from "abnormal" reflux.

With regard to the definition of reflux disease per se, endoscopy remains the primary tool. Where endoscopy proves normal, 24-hour pH monitoring assumes an important role in diagnosis, despite its limitations.[6] A 24-hour pH study which either reveals a degree of reflux which is clearly in the pathological range or which identifies a consistent association between the patient's symptom(s) and episodes of reflux is extremely helpful in planning management. While manometry does not play a major role in the diagnosis of GERD it does define the location of the lower esophageal sphincter and thus permits accurate placement of the pH probe. Manometry does however have an important role in the overall assessment of the reflux patient. Firstly, manometry will help to define those patients with primary esophageal motor disorders who are predisposed to reflux, namely those with scleroderma and mixed connective tissue disorders. Although rare, the importance of identifying these patients who commonly present with severe reflux disease cannot be overemphasized as they will have disastrous results from anti-reflux procedures. Secondly, manometry can delineate secondary changes in esophageal motor function related to long-standing reflux disease and will thereby detect those patients with severely impaired peristalsis who are likely to suffer dysphagia following a fundoplication. Finally, manometry can determine those reflux patients with a markedly hypotensive lower esophageal sphincter pressure who it has been suggested, may not respond well to medical therapy and should therefore be considered at an early stage for anti-reflux surgery.

"Non-cardiac" Chest Pain

Patients with "non-cardiac" chest pain represent a common and difficult diagnostic problem for the practicing clinician. By definition their symptom is unexplained despite an exhaustive cardiological work-up. For many, the esophagus may be the source of the problem. Extensive study over the past several years has yielded some consistent findings. Firstly, it is now clear that gastroesophageal reflux is the most common esophageal cause of non-cardiac chest pain and that this diagnosis is most likely to be provided by a 24-hour pH study.[7] Secondly, though such classical motility disorders as achalasia and diffuse esophageal spasm may,

on occasion, present with chest pain, primary dysmotility is less prevalent among this patient population than previously suspected.[8] All nevertheless deserve a detailed manometric evaluation as the treatment of reflux and dysmotility are quite different. Incorrect treatment for one when, indeed, the other is the primary problem may lead to an exacerbation of, rather than an improvement in, symptoms. Finally, it is also clear that even where abnormal motility is uncovered, reflux may still be the primary problem, such "dysmotility" commonly representing a secondary, reflux-induced phenomenon.[9] For this reason, I strongly recommend that patients with chest pain in whom a cardiac etiology has been excluded should be subjected to an evaluation for both reflux and dysmotility; this can be conveniently performed by the combination of manometry and a 24-hour pH study. Ambulatory 24-hour esophageal manometry and pH-metry are emerging as diagnostic tools for non-cardiac chest pain.

Functional (non-ulcer) Dyspepsia and Gastroparesis

The classical symptoms of impaired gastric emptying (gastroparesis) are postprandial pain and late post-prandial vomiting of partially undigested food; symptoms such as bloating, nausea and early satiety may also be prominent. Important causes of gastroparesis include diabetes, scleroderma, post-partial gastrectomy and anorexia nervosa. In some, no underlying cause can be identified - a condition termed idiopathic gastroparesis. In patients with diabetic gastroenteropathy, problems with diabetic control and in particular frequent hypoglycemic episodes may be the only manifestation of gastroparesis. A solid-phase gastric emptying study is a sensitive test for diabetic and indeed any other form of gastroparesis, and has proven to be an important starting point in the evaluation of patients with suspected gastric dysmotility. Though somewhat time consuming, this test is very well tolerated and can therefore be repeated at intervals to assess progress or response to therapy.

Functional dyspepsia is a term applied to those patients with dyspeptic symptoms without proven peptic, reflux or biliary tract disease. The etiology of functional dyspepsia is unclear, but factors such as H. pylori infection, psychological stress, dysmotility, altered vagal tone (with associated fundic and antral abnormalities in response to food) and abnormal sensation/perception, have all been proposed and investigated. The status of idiopathic gastroparesis and its contribution to the syndrome of functional dyspepsia are uncertain.[10,11] Several recent reports have consistently described a subgroup of patients, typically young females, who present with post-prandial distress, exhibit delayed gastric emptying, and on manometric study are found to have abnormal antral motility. It has been suggested, though perhaps not proven, that this subgroup is likely to respond to prokinetic agents. Motility abnormalities most frequently described among this group include an inability to generate the normal antral motor response to feeding and a relative antral hypomotility during fasting.[12]

In the evaluation of patients with unexplained vomiting, bloating or other forms of post-prandial distress, a gastric emptying study should therefore be considered and should this prove abnormal further evaluation of foregut motility contemplated. From a patient's point of view, this can now be performed with relative convenience using an ambulatory manometry system which includes solid-state miniature transducers and compact data storage systems. The recording catheter assembly is placed in the antrum and duodenum under fluoroscopic control and the patient allowed to return home while recordings continue under relatively "normal" conditions. The patient returns on the following day for retrieval of catheter and recorder and analysis of the motility study using computer software.

Small intestinal dysmotility

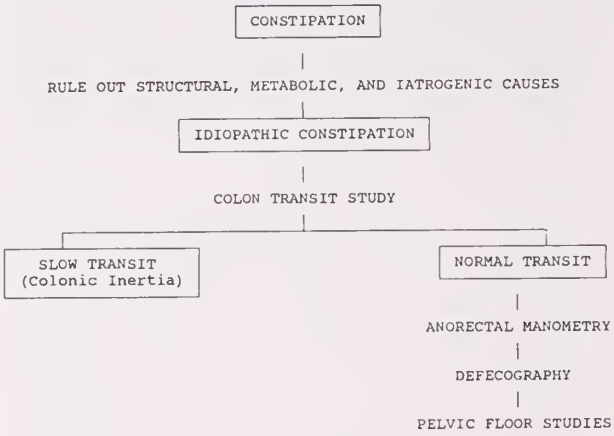
Small bowel manometry is also useful in the evaluation of patients with ileus and in differentiating patients with organic obstruction from those rare cases of intestinal pseudo-obstruction.[13,14] Small intestinal manometry may also help to separate myopathic diseases such as scleroderma, which feature low amplitude contractions, from neurogenic diseases such as diabetes, degenerative neuropathies and other myenteric plexus disorders, all characterized by disorganized motor patterns. Also of interest is that patients with irritable bowel have had patterns of minute cluster contractions found on manometry,[15] though the significance of this is unclear when compared to normal controls. Studies such as small bowel manometry take on more importance with the advent of new prokinetic agents which may prove increasingly important in directing therapy.

Colonic and Anorectal Function

A major stimulus for the assessment of co-

lonic and anorectal function in patients with constipation has been the evolution and wide acceptance of the concept of two main categories of constipation. Indeed, separate therapeutic strategies have been developed based on this subdivision. According to this concept, constipation may arise either as a result of colonic inertia (slow-transit constipation) or pelvic floor and anal sphincter dysfunction (outlet constipation). Slow transit constipation typically occurs among young females and when severe and intractable has been reported to respond well to subtotal colectomy. Individuals with outlet constipation, in contrast, demonstrate normal colonic motility; their primary problem being in the coordination of the defecatory process. Because of a failure to integrate muscles of the anal sphincter and pelvic floor, defecation becomes ineffective or even obstructed. Needless to say, subtotal colectomy proves disappointing in these patients. One of the principle goals of motility testing in constipation therefore, has been to differentiate between these two board categories and thereby to direct therapeutic efforts (Fig. 2).

Figure 2
An algorithm for the evaluation of constipation.



Colon transit can be measured quite simply and with reasonable accuracy by the ingestion of radiopaque markers contained in a single gelatin capsule on each of three consecutive days and by the radiological assessment of their progress on a plain abdominal film taken on the fourth day; colon transit can then be calculated from a simple formula.[16] By using markers of different shapes, or more sophisticated radionuclide techniques, some have even gone on to evaluate transit within different parts of the colon.

Defecography, anorectal manometry and balloon expulsion tests are but some of the techniques which have been developed to evaluate "outlet" function. Defecography can assess the effectiveness of the defecation process by monitoring pelvic floor descent and straightening of the anorectal angle - two important events during normal defecation - while the patient defecates a barium paste placed in the rectum. Anorectal manometry is utilized to evaluate rectal sphincter function and with the use of air-filled balloons, can evaluate rectal sensation. Rectal sensation has been found to be impaired in some forms of constipation - including idiopathic slow transit constipation in young women.[17] In some centers direct electromyography of the sphincter and pelvic floor muscle may also be performed to provide a more detailed assessment of the pathophysiologic process.

Incontinence is a common and socially-disabling condition. Many factors may be involved; integrity of the anal sphincter, rectal sensation and stool consistency. Here again, tests of anorectal function not only serve to facilitate diagnosis, but also guide therapy. Manometry, with radial mapping of sphincter function, may outline a focal defect resulting, for example, from previous surgery. Anorectal ultrasonography (endorectal ultrasound) is now emerging as a very sensitive and accurate technique for the evaluation of sphincter integrity. A careful manometric study may also provide the first clues of a neurogenic defect which can be further evaluated by anorectal electromyography and nerve conduction studies. It stands to reason that the identification of the integrity of the extrinsic nerve supply to the sphincters should be a prerequisite to any attempt at surgical repair - restoring muscular integrity is unlikely to succeed if the muscle is also denervated. Manometry may also be used to guide biofeedback therapy in patients with incontinence and outlet-type constipation.

Conclusions

The modern motility lab can call upon a number of sophisticated tools to facilitate the evaluation of patients with suspected dysmotility. Considerable experience has been accumulated with these techniques and guidelines have been developed to facilitate their optimum use.

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PERINATAL PAGE

Management Strategies in Transposition of the Great Vessels; 1994

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THE practice of pediatric cardiology and pediatric cardiothoracic surgery has changed appreciably over the past decade. Improvements in cardiac imaging, catheter-directed interventions, and trends toward earlier anatomic surgical repair highlight the changes in this subspecialty. Neonatal repair of transposition of the great vessels is a prime example of the evolution of care of patients with congenital heart disease.

Transposition of the Great Arteries

Transposition of the great arteries denotes a condition in which the atrioventricular connection is concordant (RA to RV, LA to LV) with the ventriculo-arterial connection being discordant. (RV to aorta, LV to PA). Approximately 75% of children born with TGA have an intact or nearly intact ventricular septum, while the remainder have a ventricular communication. The physiology of transposition is predominated by the fact that deoxygenated (blue) blood returns to the heart, only to be pumped from the right ventricle to the systemic circulation (aorta). Oxygenated (red) blood returns to the pulmonary venous atrium only to be pumped by the left ventricle to the lungs again. This example of parallel circuits is incompatible with life unless adequate mixture of the two circuits is allowed. This mixing of oxygen and deoxygenated blood can occur through an atrial or ventricular communication, or at the level of the ductus arteriosus.

Clinical Presentation

Infants born with transpositon of the great vessels present with varying degrees of cyanosis. The level of cyanosis is dependent on the amount of cardiac mixing. Commonly, patients do not have any cardiac murmurs.

Historical Perspective

In 1959, Senning accomplished the first physiologic correction of transpositon of the great arteries using the native right atrial wall and atrial septum to redirect or switch the venous inflow, leaving the RV pumping oxygenated blood to the aorta. An initial attempt was made to switch the great vessels but technical problems led Mustard to modify Sennings atrial repair incorporating an intra-atrial pericardial baffle after excision of the atrial septum. These two atrial techniques were accepted worldwide as the treatment of choice for transpositon of the great vessels for many years. In 1976 Jatene from Sao Paulo, Brazil reported a successful technique for switching the great vessels and translocating the coronary arteries.

Why Arterial Rather than Atrial Switch?

A great deal of anatomic and physiologic data support the concept that the left ventricle is better suited than the right ventricle to function as a systemic pump. The right ventricular cavity is crescent shaped and its bellows-like contraction pattern is ideally suited for pumping against the low resistance pulmonary circuit. In contrast, the left ventricle is ellipsoid shaped and its concentric contraction favors the pressure work required to pump to the systemic circulation. Although many patients have functioned well after the Senning or Mustard procedure, increasing data support the concept that the morphologic right ventricle is likely to become dysfunctional when used long term as a systemic ventricle. Virtually all patients post artial switch have an abnormal ejection fraction response to stressful exercise. Significant tricuspid valvular regurgitation, atrial and ventricular arrhythmias, pump failure and sudden death have been reported as late complications after the atrial inversion procedure. Intuitively, the arterial switch procedure, which allows the left ventricle to be the systemic pump, is extremely attractive.

Management

In the past, patients born with TGA underwent cardiac catheterization with balloon atrial septostomy in the first week of life to promote adequate venous mixing between the two par-

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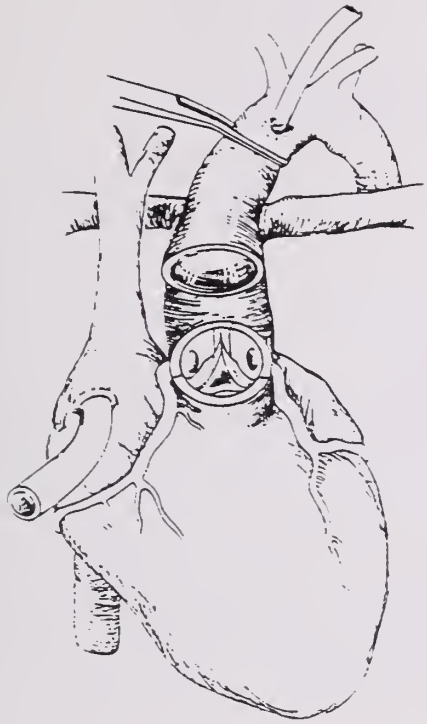

FIGURE 1
Division of ascending aorta approximately 1 cm distal to valve commissures. Patient ductus arteriosus divided.

FIGURE 3
Distal pulmonary artery is brought anterior to the ascending aorta (LeCompte maneuver). Anastomosis of proximal neoaorta to distal aorta.

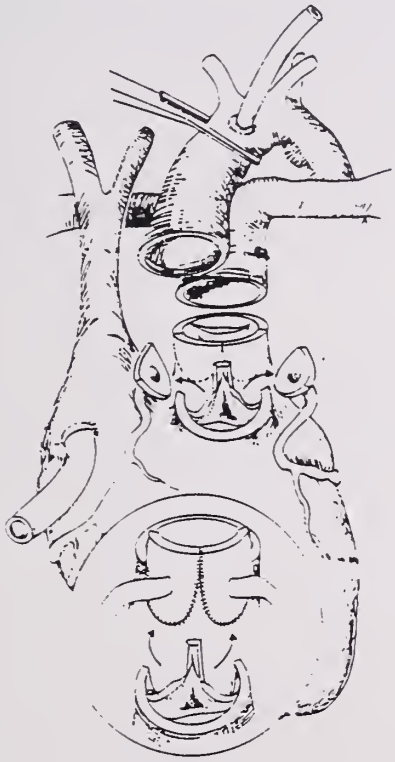

FIGURE 2
Excision of left and right coronary arteries with generous patch of aortic wall. Division of main pulmonary artery. Excision of segments of pulmonary artery wall (see inset), transfer of coronary arteries, and anastomosis of both left and right coronary arteries into neoaorta.

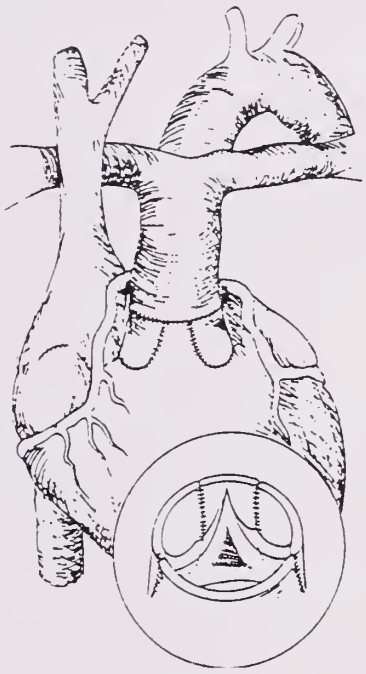

FIGURE 4
Coronary site from neopulmonary artery filled with pericardial patches (see inset). End-to-end anastomosis between the proximal neopulmonary artery segment and the distal pulmonary artery. The branch pulmonary arteries were extensively mobilized at the beginning of the procedure.

(Reprinted with permission from Long WA. Fetal & Neonatal Cardiology, Philadelphia, W.B. Saunders, 1990; Figures 1,2 pg 792, Figures 3,4 pg. 793).

allel circuits. The patients then underwent Mustart or Senning procedure at six months to one year of age.

Presently, cardiac catheterization is not always indicated for patients with transposition of the great vessels. Balloon atrial septostomy is performed only when the patient has inadequate mixing and surgical repair cannot be performed in an expedient manner. With improvements in echocardiography, fewer patients will need cardiac catheterization to define coronary artery anatomy.

For simple transpostion, the arterial switch is performed in the first 14 days of life. Although safely performed after three weeks of age, surgical mortality increases with increasing patient age. The physiologic basis for this age-dependent mortality is involution of left ventricular muscle mass as pulmonary vascular resistance drops. The left ventricle becomes "unprepared" to serve as the systemic pump. In TGA with a large ventricular septal defect and equal right and left ventricular pressures, the arterial switch procedure can be performed at a later time, although the risk of pulmonary hypertension also increases in these patients.

Few contraindications to performing the arterial switch procedure exist. One major problem, however, is obstruction to left ventricular outflow at the level of the pulmonary valve or subvalve level that may preclude using this as the neo-aortic valve. Some coronary artery arrangements, including single coronary, may increase the surgical risk although nearly all arrangements can be translocated successfully. Switching of the great vessels and coronary arteries is depicted in Figures 1-4.

Follow-up

Longer term follow-up data is now becoming available for patients with TGA who undergo the Jatene arterial switch procedure. Unlike patients with the Senning or Mustard procedure, oxygen delivery and exercise tolerance are normal. The patients do not appear at risk for significant arrthythmias or sudden death. Life-long effects of coronary reimplantation are, as yet, unknown, but circumferential growth of the coronary buttons and the great arteries has been documented.

Conclusions

Despite being born with complex cyanotic heart disease, the future looks very bright for patients who undero a successful arterial switch procedure for transpostion of the great vessels.

ORTHOPEDIC CASE REPORT

Metatarsophalangeal Joint Subluxation

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Forefoot pain is a frequent complaint of individuals presenting to an orthopaedic surgeon or family practitioner. Frequently the pain localizes to the second metatarsophalangeal joint. Discomfort at this location may be secondary to degenerative arthritis, an interdigital neuroma, local mainifestations of systemic arthritis, synovial cysts, osteonecrosis of the metatarsal head, and non-traumatic synovitis of the metatarsophalangeal joint.[1,2,3] Non-traumatic synovitis frequently involves the second MTP joint, may mimic an interdigital neuroma, and may go unrecognized.[3] It is the purpose of this report to present a case of this disorder and to briefly discuss its treatment.

CASE REPORT

SK is a 55 year old female who presented with left forefoot discomfort. She had a previous history of borderline diabetes for eight years controlled with Glucotrol and diet. Her past surgical history is remarkable for an excision of a left third interspace neuroma as well as a second toe hammertoe procedure. At the time of presentation she complained of numbness and tingling throughout multiple lesser toes. She also had focal discomfort on palpation of the second and third metatarsal heads of the left foot.

Her physical examination was remarkable for a longitudinal incision over the interspace between the 3rd and 4th toes as well as transverse incision over the second PIP joint. Examination also showed slightly decreased sensation over the left third toe and prominent plantar calluses over the 2nd and 3rd metatarsal heads. The patient had a small third toe hammertoe deformity. Doppler and monofilament examinations were normal. The foot mat showed prominent metatarsal heads at the 2nd and 3rd toes. AP and lateral radiographs (fig. 1a, 1b) demonstrated sublxation of the left 2nd metatarsophalangeal joint and frank dorsal dislocation of the 3rd metatarsophalangeal joint. Based on the normal monofilament examination the patient's complaints of tingling were not attributable to a peripheral neuropathy. Her second and third toe metatarsalgia was secondary to the subluxation and dislocation respectively. Lastly, the patient had some discomfort secondary to the 3rd hammertoe deformity.

The patient was treated with a left 2nd toe MTP arthroplasty, a left 3rd toe MTP arthroplasty and a left 3rd toe hammertoe procedure. Additionally, the patient had a negative exploration of the 3rd and 4th interspace for residual neuroma. Postoperative AP and lateral radiographs (Fig. 2a, 2b) show reduction of the metatarsophalangeal joints. Surgical intervention involved release of the dorsal capsule, extenor tendon and collateral ligaments of the MTP joints of the 2nd and 3rd toes with excision of a small amount of the distal aspect of the 2nd and 3rd metatarsal bones as well as a portion of the proximal phalanx of the third toe. The hammertoe was corrected with a standard hammertoe procedure including resection of a small portion of the distal aspect of the 3rd proximal phalanx.

DISCUSSION

The etiology of metatarsophalangeal joint subluxation and dislocation is not conclusively known.[4] Synovitis in that joint can led to subluxation and subsequently to frank dislocation with the development of metatarsalgia. A long second ray may cause the phalanx to ride dorsally.[1,5] This in turn leads to shortening of the extensor tendon and dorsal capsule with elongation of the plantar capsule. Normal dorsiflexion of the MTP joint during walking tends to exacerbate the deformity.[3,6] The deformity may be seen in association with hallux valgus leading to lateral and/or dorsal deviation of the 2nd toe relative to the metatarsal bone.[2,3,6] Another variation seen in individuals who have crossover toes involves medial diviation of the proximal phalanx.[1] Finally, the base of the proximal phalanx of the 3rd toe may impinge upon the metatarsal head of the 2nd toe giving rise to medial and/or dorsal subluxation of the second toe proximal phalanx.[1,2,3] Symptoms typically involve pain in the intermetatarsal space particularly with ambulation. Additionally, there is pain directly under the metatarsal head. Typically there is no rest pain. In

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FIGURE 1A
Preoperative AP radiograph

FIGURE 1B
Preoperative lateral radiograph

contrast to the pain of an interdigital neuroma there is typically no radiation of pain to the toes or numbness. Additionally, compression of the transverse metatarsal arch usually does not elicit pain.[2] There may be pain dorsally over the MTP joint secondary to the over-riding proximal phalanx. Additionally, patients may have a painful intractable plantar keratosis overlying the metatarsal head.[1,2,3] Attempts to vertically sublux the toe may place pressure on the plantar capsule and lead to pain.[5] Patients may present with either a subluxation or dislocation that is readily correctable or with a complete dislocation that is not reducible. A third type is a complete dislocation with an associated hammertoe deformity as seen in the 3rd toe of our index case.[3] Lastly, patients may present, as previously mentioned, with a cross-over toe deformity.[1,3]

Important findings on anterior-posterior radiographs include a decrease in the normal 2-3mm clear space at the articular surface of the metatarsophalangeal joint, overlap of the proximal phalanx and the metatarsal head, and a change in the normal 12^0 lateral inclination of the proximal phalanx relative to the metatarsal shaft. On the lateral projection the proximal phalanx is seen dorsal to the metatarsal.[2]

Initial management typically is conservative particularly in the setting of subluxation prior to

frank dislocation. Discomfort often can be controlled with the use of taping, a toe loop, appropriate extra depth shoes, metatarsal pads, lowering of the heel, and non-steroidal anti-inflammatory medications.[2,3,5] If patients fail conservative therapy then surgical therapy is considered. For patients with a reducible subluxation or dislocation the dorsal capsule and collateral ligaments are released and the extensor tendon is lengthened. A synovectomy is performed to help decompress the joint. Adhesions are released between the plantar capsule and metatarsal head. If the joint remains reduced in dorsiflexion routine closure is performed. The toe is held in slight plantar flexion for 3-6 weeks with either a dressing or a K-wire.[2,3,5] In more recalcitrant cases with complete dislocation, the initial dorsal release is performed and the distal portion of the metatarsal head is removed as well in order to further decompress the joint. If patients have an associated plantar keratosis then a plantar condylectomy is performed. The stability is again checked in dorsiflexion and then after routine closure, K-wire fixation again holding the toe in plantar flexion is done for 3-6 weeks.[2,3,5] A flexor tendon transfer often is necessary to transfer a plantar flexion force to the proximal phalanx for additional stability.[1,2] For individuals presenting with an associated hammertoe deformity the surgical procedure for the metatarsophalangeal joint dislocation is performed as already described and the hammertoe is then corrected with a dorsal transverse incision over the PIP joint with excision of the distal protion of the proximal phalanx.[2,3] Some authors also recommend releasing the long flexor tendon.[3] Lastly, individuals presenting with a cross-over toe may have subluxation at the MTP joint.[1] This is addressed with dorsal and mediolateral capsulotomy, appropriate capsular reefing, and a transfer of the flexor digitorum longus tendon to the medial and lateral sides of the proximal phalanx with the toe held in 20^0 of plantar flexion.[1] If there is frank dislocation at the MTP joint in association with a crossover toe, resection of a portion of the metatarsal head typically is necessary in order to reduce that joint.[1] partial proximal phalanx excision and sub-

FIGURE 2A
Postoperative AP radiograph

FIGURE 2B
Postoperative lateral radiograph

total webbing is an alternative approach to address subluxation or dislocation at the metatarsophalangeal joint.[6]

In summary, patients frequently complaining of forefoot pain may have subtle radiographic findings of subluxation of the metatarsophalangeal joint. Often this may be unrecognized and the patient's discomfort may be incorrectly attributed to an interdigital neuroma. Particularly when the pain occurs at the second toe, an uncommon area for an interdigital neuroma, clinical suspicion of 2nd metatarsophalangeal joint synovitis and/or subluxation should be aroused. Initial management is conservative with non-steroidal anti-inflammatory medications, a toe loop, and extra depth shoes. Should the patient fail these measures then orthopaedic referral for possible surgical intervention is appropriate.

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ALLIANCE

Domestic Violence — Think About It!

LYNNE RUSTAD
Legislation Chair

Domestic violence knows no color, race, political affiliation, social economic status or age.

It is: The leading cause of injury to women! More common than accidents, muggings or rape.

- Every 17 seconds a woman is the victim of a violent crime
- Nine (9) out of ten (10) women who are murdered are killed by men
- Four (4) out of five (5) are murdered at home
- Three (3) out of (4) are killed by their husbands

76% of all women coming to Nebraska's network for domestic violence programs reported injury resulting from battery.

30% of all pregnant women are battered.

35% of all women seeking treatment in emergency rooms have been battered.

50% of the women in chemical treatment centers are victims of battering.

Battering precipitates one (1) in every five (5) suicide attempts.

From June 1, 1993 to June 30, 1994, throughout Nebraska, 68,061 **calls** were made to Domestic Crisis Hot Lines.

And for every woman who is a victim of domestic violence — there are other victims . . . her children.

Every year 3.3 million children witness their fathers beating their mothers.

Children in homes where domestic violence occurs are physically abused or seriously neglected at a higher rate of 1,500% higher than the national average.

Physical abuse of children in violent homes is 129% higher than non-violent homes.

70% of children who stay at battered women's shelters have been abused or neglected.

DOMESTIC VIOLENCE AFFECTS A CHILD FOR A LIFE TIME

- The most common factor among pregnant teens is that they grew up in violent homes.
- Children who witness violence in their homes are 25% more likely to commit sexual assault.
- 6% more likely to commit suicide.
- 74% more likely to commit a crime against another person.
- 50% more likely to use alcohol and drugs.

Over 5,000 women ran from their homes with their children to the safety of shelters last year in Nebraska, along with them . . . their children.

It is imperative that we look at these women and their children and recognize who they are, what they have survived and what they need from us.

Violence against women is an urgent public health problem that has devastating physical and emotional consequences for women and children.

They need an understanding from their community and lawmakers and a caring commitment from the medical community.

This is one woman's story.

"After each beating I drove myself to the hospital with two babies under my arms, and 14 times, doctors patched me up and sent me back home. Not once did they question my story about bumping into doors. Even the pediatrician who saw me on regular basis, never questioned the obvious marks."

Gloria, a 45 year old
Omaha business woman

Are you interested in helping to sponsor a bill that will protect women like Gloria and her children?

Please call with your support and ideas.

Thank you, Lynn Rustad (402) 488-7615 or Sally Semm (402) 421-2250.

ASK A LAWYER

CHARLES M. PALLESEN, Esq.
1900 FirsTier Bank Building
Lincoln, NE 68508

1. Who may execute an anatomical gift?

The Uniform Anatomical Gift Act, Neb. Rev. Stat. § 71-4802, states that any individual of sound mind and nineteen years of age or older may give all or part of his or her body for education, research, advancement of medical or dental science, therapy or transplantation. Additionally, the following persons, listed in order of priority, may donate all or part of an individual's body upon death for any of the purposes listed above:

1. The spouse,
2. An adult son or daughter,
3. Either parent,
4. An adult brother or sister,
5. A guardian of the person of the decedent at the time of his or her death, and
6. Any other person authorized or under obligation to dispose of the body.

The persons authorized by this subsection may not execute the gift (and receivers of the anatomical gift may not accept the gift) if they know the deceased individual opposed such a gift, or if they know a member of the same or a prior class opposes the gift. The authorized persons can make this decision either after or immediately before the individual's death. Under the law, the authorized individuals execute the gift by signing a document or by recording a message (e.g., telephone message or telegraph message).

2. In making an anatomical gift, can a donor specify the physician who will carry out the appropriate procedures?

Yes. Nebraska law allows the donor to make the gift to a specified person or to designate the surgeon or physician to carry out the appropriate procedures. In absence of such a designation, or if the specified person is unavailable, the attending physician may accept the gift as the donee.

Neb. Rev. Stat. § 71-4804 permits anatomical gifts to be made in a variety of other ways as well. First, an individual may execute an anatomical gift by will. Under a will, the gift becomes effective upon death without waiting for probate. Second, an individual may execute an anatomical gift with a document other than a will. Like a will, the document activates the gift upon the donor's death. The document must bear the signature of the donor, and the donor's signature must be witnessed by two people. The two witnesses must also sign the document in the presence of the donor. If the donor is unable to sign, the donor may direct someone to sign in his or her presence and in the presence of two witnesses. A third alternative allows individuals to indicate their intent to make an anatomical gift on their drivers' licenses. This method appears to be the simplest way of expressing an intention to make an anatomical gift.

3. If the donor later changes his or her mind, can the donor amend or revoke the anatomical gift by stating this intention to an attending physician?

Yes, if the statement is made during a terminal illness or injury. According to Neb. Rev. State. § 71-4806, the manner in which a donor amends or revokes the gift depends on the form of the gift. If the gift was made by a will, card or other document which has been delivered to a specified donee, the donor may amend or revoke the gift by: (1) executing and delivering a signed statement to the donee; (2) making an oral statement in the presence of two witnesses and communicating the intention to the donee; (3) making a statement to an attending physician during a terminal illness or injury and communicating the intention to the donee; or (4) signing a card or document which remains in the donor's possession until his or her death. If the document regarding the gift has not been delivered to the donee, the gift may be revoked by any of the methods mentioned above, or by destruction, cancellation or mutilation of the document and all executed copies of the document. Any gift

made by a will may also be amended or revoked in the same manner that a will is amended or revoked.

4. Who may consent to donate blood and human tissues for the purpose of injection, transfusion, or transplantation?

Neb. Rev. Stat. § 71-4808 states that any individual of sound mind and seventeen years of age or older may consent to donate whole blood, and any individual of sound mind and nineteen years of age or older may consent to donate other human tissues such as corneas, bones, or organs for the purpose of injecting, transfusing, or transplanting such blood or other human tissues in the human body. An individual aged seventeen or eighteen must obtain parental permission or authorization before receiving compensation for any donation of whole blood.

***

"Ask a Lawyer" is a feature of the **Nebraska Medical Journal**. If you have a legal question of general interest, please write the **Nebraska Medical Journal.** Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline, Williams, Wright, Johnson & Oldfather, 1900 FirsTier Bank Bldg., Lincoln, NE 68508. Answers in this issue were provided by Charles M. Pallesen with the assistance of Creighton Law School student Michele M. Mellor of the Cline, Williams Law Office. Questions relating to specific detailed factual situations should continue to be referred to your own counsel.

"WOW!!! NOW I SEE WHY YOU'RE SO JOLLY ALL THE TIME."

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COVER ARTIST

The artist for this month's cover, Vera Benson, is a resident at Bethany Home in Minden, Nebraska. Vera is a former secretary who developed severe arthritis about twenty years ago, forcing her to retire. She has been a resident at the home for fifteen years. Carol Dolan, Activities Director at Bethany Home writes the following about Vera: "She has had dozens of surgeries over the past years, including several joint replacements. Every time she is left a little more determined to turn her disability into "ability". She knows no defeat. Vera always finds some type of craft or art to meet her "ability". She helps in any way she can in the activity department. Vera has been resident council president for six years and an officer for seven. She keeps everything moving along and makes sure we all get the job done." Carol notes that Vera is not only an artist, but also a poet, having written poems for several occasions. She also is active in other crafts and in sewing.

Thank you, Vera, for your contribution to the cover of the **Nebraska Medical Journal.**

COMING MEETINGS

CREIGHTON UNIVERSITY

JANUARY 20, 1995 — Vestibular and Balance System Assessment: Theory, Methodology and Treatment, Department of Otolaryngology, Boys Town National Research Hospital Auditorium, Omaha, NE.

FEBRUARY 11, 1995 — Management of Colon and Rectal Diseases by the Primary Care Physician, Marriott Hotel, Omaha, NE.

MARCH 23, 1995— Distinguished Lecture Series - James N. Baraniuk, M.D. - Boys Town National Research Hospital Auditorium, Omaha, NE.

MAY 6-7, 1995 — Anesthesiology Conference, Marriott Hotel, Omaha, NE.

MAY 26-28, 1995 — Family Medicine Update, Village East Resort, Okoboji, IA.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite #2130, Omaha, NE 68131.

MAYO FOUNDATION

FEBRUARY 1-8, 1995 — Update in Clinical Neurophysiology, Mayo Clinic, Rochester, MN.

FEBRUARY 4-8, 1995 — Selected Topics In Internal Medicine, Silverado Resort, Napa Valley, CA.

FEBRUARY 9-11, 1995 — Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management, Silverado Resort, Napa Valley, CA.

MARCH 24-26, 1995 — Advances in Clinical Anesthesiology, Silverado Resort, Napa Valley, CA.

For further information: Contact Postgraduate Courses, Section of Continuing Medical Education, Mayo Foundation, Rochester, MN 55905, Phone: Toll Free 800-323-2688 (U.S.).

NEBRASKA MEDICAL ASSOCIATION

ANNUAL SESSION — House of Delegates, April 24-26, 1992, Marriott Hotel, Omaha.

FALL SESSION— House of Delegates, September 10-12, 1992, Cornhusker Hotel, Lincoln.

ANNUAL SESSION — House of Delegates, April 22-25, 1993, Cornhusker Hotel, Lincoln.

FALL SESSION— House of Delegates, September 9-11, 1993, Cornhusker Hotel, Lincoln.

ANNUAL SESSION — House of Delegates, April 28-May 1, 1994, Marriott Hotel, Omaha.

FALL SESSION— House of Delegates, September 15-17, 1994, Cornhusker Hotel, Lincoln.

UNIVERSITY OF NEBRASKA MEDICAL CENTER EMERGENCY MEDICAL SERVICES

DECEMBER 1, 1994, THURSDAY — Advanced Cardiac Life Support (ACLS) Renewal. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's, Allied Health Professionals. Credit: 7 Hours AMA Category I, 8.0 Prescribed Hours AAFP. Fee: $110.

DECEMBER 2, 1994, FRIDAY — Advanced Cardiac Life Support (ACLS) Instructor. University of Nebraska Medical Center Campus, Omaha, Nebraska. Target Audience: Physicians, Nurses, PA's Allied Health Professionals. Credit: 6 Hours AMA Category I, 7.0 Prescribed Hours AAFP. Fee: $125.

DECEMBER 2, 1994, FRIDAY — Pediatric Advanced Life Support (PALS) Instructor, University of Nebraska Medical Center Campus, Omaha, Nebraska. Credit: 4 Hours AMA Category I, 4 Hours Prescribed Hours AAFP. Fee $50.

For further information: Contact Cindy Hanssen, University of Nebraska Medical Center, Center for Continuing Education, 600 So 42nd Street, Omaha, Nebraska 68198-5651. Call (402) 559-5919 or use our toll free MD ADVANTAGE NUMBER AND ASK FOR CONTINUING EDUCATION (1-(800)652-1095 NATIONWIDE. FAX NUMBER (402) 559-5915.

COMING MEETINGS

UNIVERSITY OF NEBRASKA MEDICAL CENTER

DECEMBER 1-3, 1994, THURSDAY-SATURDAY — Obstetrics and Gynecology Conference, Bally's, Las Vegas, Nevada. Target Audience: Primary Care Physicians, Obstetricians and Gynecologists. Fee: $275.

MARCH 5-10, 1995, SUNDAY-FRIDAY — 15th Annual Keystone ENT Conference, Keystone Resort, Keystone, Colorado. Target Audience: Otolaryngologists, Facial Plastic Surgeons, Allergists, Primary Care Physicians. Fee: $400.

MARCH 27-APRIL 7, 1995, 11 DAYS — Family Practice Review, Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

APRIL 24-MAY 5, 1995, 11 DAYS — Family Practice Review , Center for Continuing Education, UNMC, Omaha, Nebraska. Target Audience: Family Physicians. Fee: $1150 - two week session, $800 - one week session, $1300 - split sessions.

JUNE 2-3, 1995, MONDAY-TUESDAY— Nuclear Antigens as Targets for Cancer Therapy, Red Lion Hotel, Omaha, Nebraska. Target Audience: Oncologist/Hematologists and Researchers.

JUNE 9-10, 1995, FRIDAY-SATURDAY — 3rd Annual Diagnostic Dilemmas in Women's Health Care, Omaha, Nebraska. Target Audience: Family and General Practice, Internists, Obstetricians and Gynecologists, Emergency Physicians, Physician Assistants. Fee: $200.

ONGOING CONTINUING MEDICAL EDUCATION PROGRAMS

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These programs are offered by the Center for Continuing Education throughout the year.

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NEBRASKA MEDICAL JOURNAL 1994 Scientific Article Award For Medical Students and Residents

GUIDELINES:

1. Articles submitted by a medical student or resident in a Nebraska program may be considered for an award from the Nebraska Medical Journal.
2. Resident or student must be the first author of the article and must have carried out a major portion of the work.
3. The scientific work must have been carried out while the author was a resident or student. Work that has been presented but not published is eligible to be submitted for publication.
4. The resident or student must indicate at the time the article is submitted that the article is to be considered for the award.
5. Articles will be judged by members of the Editorial Board of the Nebraska Medical Journal.
6. A 1994 award of $1,000 has been determined by the Board of Directors of the Nebraska Medical Association.
7. The award will be presented at the Nebraska Medical Association Annual Session in April, 1995.
8. The award will be presented for an article published in calendar year 1994. Residents and students should be aware that due to review requirements and typesetting, the length of time between submission and publication may be several months. The Editor/Editorial Board reserve the right to decline publication of any material submitted.
9. Each issue of the Nebraska Medical Journal contains an "Advice to Authors" notice which describes format requirements for manuscripts submitted.

Articles Should Be Submitted To:

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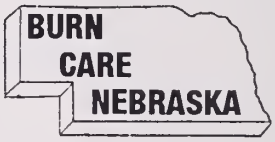

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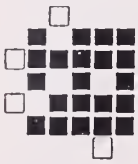

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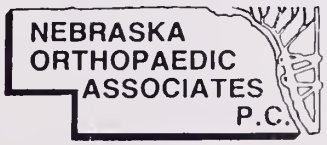

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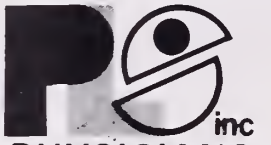

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Nebraska Medical Journal

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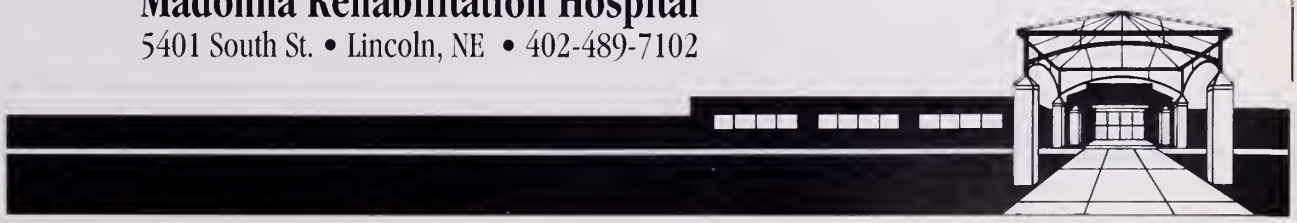

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The Nebraska Medical Journal

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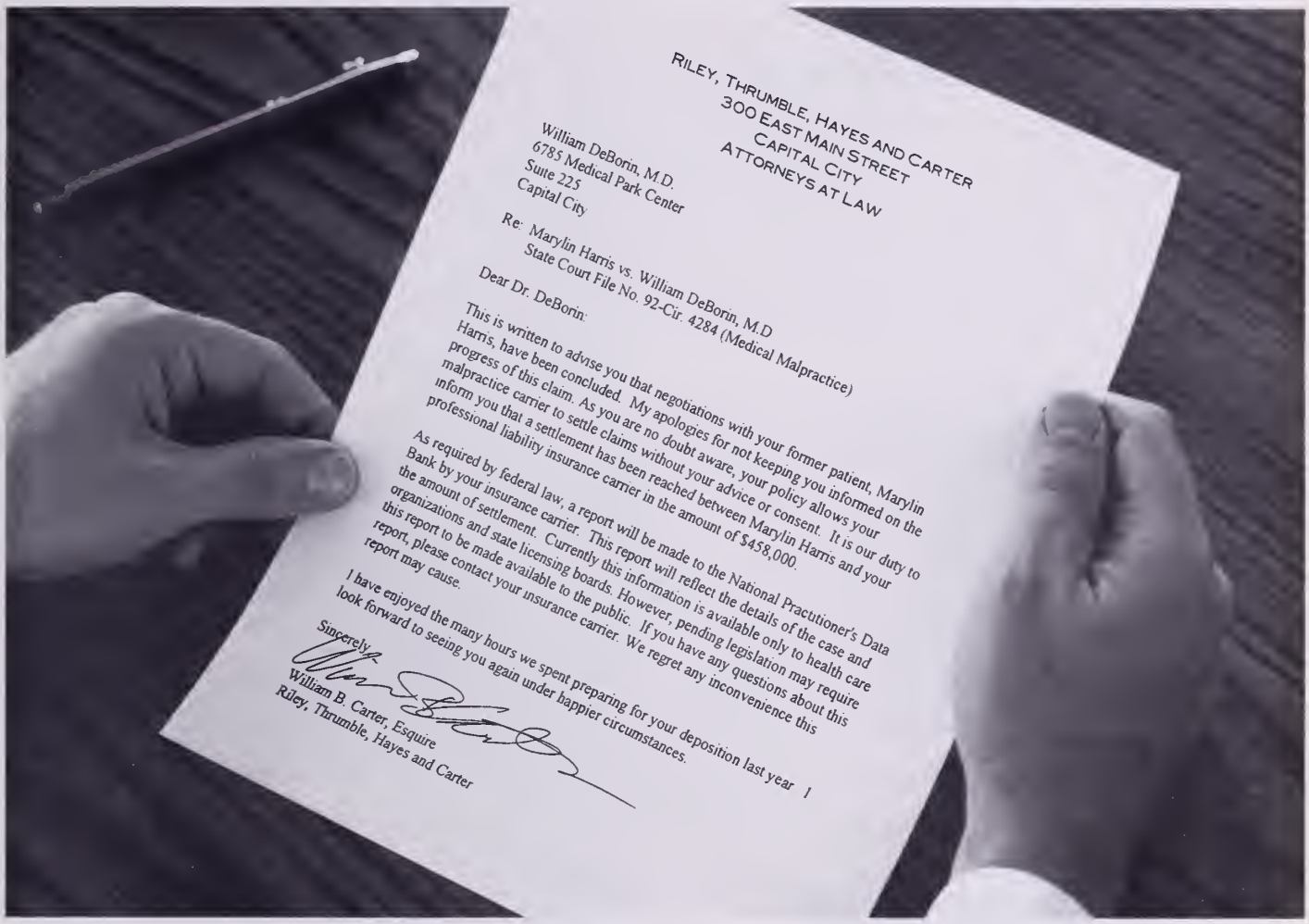

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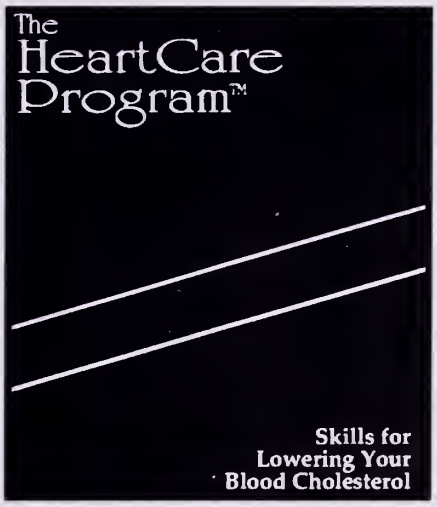

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PRESIDENT'S PAGE

The "Any Willing Provider" Provision and Health System Reform in Nebraska

FREDERICK F. PAUSTIAN, M.D.

During the past year the American Medical Association, and more recently, the Nebraska Medical Association in it's House of Delegate meeting, September 16-17, 1994, moved away from aggressive pursuit of the "Any Willing Provider" (AWP) provision in legislation pertaining to health system reform. The intent of the AWP provision was to protect patient freedom of choice of physician. Classically an AWP provision prohibits a managed health care plan such as an HMO from denying providers in a specified class from contracting with the plan if the provider is willing to accept its terms and conditions. The Nebraska Hospital Association, the managed health care industry, and more recently, physician directed organizations, and physician hospital organizations have taken strong positions against AWP legislation for the following reasons:

1. Prevents restricting physician panels to only the highest quality health professionals.
2. Undermines selective contracting as a primary means of controlling health care costs (i.e. negotiating discounts with a select group of providers in exchange for a large guaranteed patient volume).
3. Prevents limiting the number of providers participating in an organizational network which results in increased administrative liability and the broadening of quality assurance and utilization review programs thereby increasing administrative costs.

The problem becomes further compounded when AWP legislation includes many other categories of health care providers. Minnesota legislation, for example, requires health plans to establish expanded networks that include outpatient chemical dependency specialists, licensed marriage and family therapists, home health care providers, occupational therapists, nurse practitioners, optometrists, chiropractors, pharmacists, audiologists, dieticians, and opticians. It is very difficult to limit AWP legislation to just physicians as M.D.'s and D.O.'s.

Frederick F. Paustian, M.D.

While health system reform legislation at the national level is currently less imminent, it is very important for the NMA to take an aggressive role in the formulation of health system reform at the state level. By so doing, we can focus on the needs of the citizens of the State of Nebraska while taking into consideration the social and economic conditions prevalent within the state. Among a variety of meetings in which I have participated there has been a common theme expressed as to the need for looking at health system reform from the perspective of the consumer of health care services, namely the patient rather than health care providers, the health insurance industry, employers and government. The AMA Patient Protection Act (PPA) strives very hard to obtain that goal. Among the essential elements of the PPA is a requirement for every managed care plan which limits access to physicians to only those under contract to offer a "point of service" option which allows policy holders (patients) within the plan to access physicians outside the plan or network. The need for such access is patient determined with reasons ranging from dissatisfaction to perceived better quality of care outside of the network. Such access to physicians outside of the managed health care plan can only come at a higher cost because of the lack of controlling terms and conditions. Therefore,

the patient's freedom of choice of physician can be expected to be more expensive. The increased cost to the payers (health insurance carrier) can be offset by offering the point of service (freedom of choice of physician) as an option to the basic managed care system plan at an additional premium. Other patient born costs under such an option would be co-pays to physicians and deductibles in respect to hospitalizations and certain medical care services. The overall cost of such an option would best be determined by market forces, namely competition and the security the delivery system has in the quality of its providers.

Other features of the AMA's PPA which warrant strong support are as follows:

1. Managed care plans must provide information to policy holders and prospective enrollees regarding the terms and conditions of the plan including coverage provisions and exclusions, prior authorization or other review requirements, and plan limitations.
2. Require managed health care plans to have a mechanism for physician and consumer input into the determination of the plan's medical policies.
3. The plans must make available to the applicants and enrollees their provider selection criteria and performance profiles.
4. There must be prevention of disruption of continuity of care as the result of deselection of physicians without appropriate hearings which include due process.

There are many other provisions within the AMA's state version (June 1994) of the PPA which warrant inclusion in Nebraska's plan for health system reform. The focus of this commentary, however, is an alternative proposal to the AWP provision through the mechanism of the point of service option.

The blunting of the health system reform plan of the current administration would not have been possible without the concerted effort of numerous people and organizations such as the AMA, Small Business Association, health insurance industry, hospital associations, etc. We must now take advantage of the opportunity to focus on health system reform relative to those aspects which need improvement rather than all encompassing reform which has the significant potential of decreasing the quality of medical care and at the same time increasing markedly the costs. The participation of all physicians within the State of Nebraska during the forthcoming legislative session relative to health system reform is critically important in order that we may safeguard the current quality of health care for the citizens of our state and at the same time provide them with the opportunity to select their source of medical care without undue constraint.

The officers and leaders of the Nebraska Medical Association together with its administrative staff wish all of you joyful holidays and very happy, successful and healthy New Year.

GUEST EDITORIAL

Are the Germs Winning?

RICHARD A. MORIN, M.D.

In the September 12, 1994 issue of TIME news magazine the perils of antibiotic resistant bacteria was delineated in great detail. The concept of resistant bacteria is by no means new. Medical microbiologists, for years, have recognized and studied the many mechanisms that bacteria have evolved to circumvent various antibiotics. Perhaps what is new is that more and more antibiotic resistant organisms are being recognized as significant pathogens in the clinical setting.

In a response to emerging antibiotic resistance, new antibiotics with broader spectrum of antimicrobial activity (. . . and increase cost) have been introduced. Many of these antibiotics were initially promoted by pharmaceutical companies as being incapable of bacterial deactivation. Such claims have been discarded when bacterial resistance to these agents could be demonstrated in clinical and research microbiology laboratories. In some situations, the rate of induced resistance was actually accelerated.

The best way to prevent antibiotic resistant bacterial evolution is to not use antibiotics. Obviously this admonition would remove a significant portion of the medical armamentarium against human disease and suffering. A better approach to decreasing antibiotic resistance is the practical and prudent use of antibiotics in clinical practice.

The practical use of antibiotics is based on two assumptions:

1. There is no perfect antibiotic that can kill all pathogens in all clinical situations.
2. Any bacteria, given sufficient environmental pressures, can evolve into a more resistant and survivable state that can be passed to future generations of bacteria.

Based on these assumptions, a list of antibiotic guidelines can be derived.

- Use antibiotics to treat bacterial infections that will respond to the antibiotics. Viral infections can be complicated by secondary bacterial infections, but treating viral infections with antibiotics does not necessarily prevent or reduce rates of secondary infections.

- Establish time limits and objectives when starting empiric antibiotic therapy. If therapeutic objectives have not been achieved within the established time limit, then a more detailed diagnostic evaluation can be undertaken rather than giving more antibiotics.

- Incorporate non-antibiotic therapies into antibiotic treatment of infections. Surgical drainage of an abscess will promote a quicker resolution of infection thus negating the need for long term antibiotics.

- Long-term antibiotic therapy should be used sparingly with established diagnostic guidelines to dictate length of therapy. Serial laboratory studies or repeated radiological studies can determine progress and response to antibiotics.

- Do not use antibiotics to irradicate chronic bacterial colonization. Antibiotics do not prevent onset of infections such as urinary tract infections in patients with long term bladder catheterization.

- Be aware of specific limitations of individual antibiotics. Ciprofloxacin has poor activity against the Streptococcal species and thus would not be an ideal antibiotic option in treating Streptococcal pharyngitis.

- Take the opportunity to educate patients about antibiotics and the need to complete prescribed antibiotic courses. Warn patients not to hoard antibiotics.

- Take the opportunity to educate fellow health care providers including physicians assistants, nurse practitioners and others.

- Know antibiotic sensitivity patterns of common pathogens in your community. Antibiotic sensitivity data is collected by the microbiology laboratory and can provide the clinician with a guide for use of empiric antibiotics.

These suggestions are a guideline to clinicians. Ultimately, the use of antibiotics must be dictated by the patient's clinical situation.

Are the germs winning? Not yet!!!

COMMUNICATION

Pharmacy Cognitive Services and Mail Order Pharmacies

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I applaud the editorial authored by Dr. Bastani in the August issue.[1] He has highlighted a concern we in the pharmacy profession share and are presently studying at the University of Nebraska Medical Center College of Pharmacy. In many Nebraska communities, employers have demanded their employees convert to the mail order pharmacy of the employer's choice. Yet, when these patient have questions regarding their drug therapy they are still inclined to telephone their long-standing neighborhood pharmacist to receive personalized pharmaceutical care. These pharmacists provide these cognitive services to these patients at no charge but such practices (i.e., no reimbursement) are threatening the delivery of pharmaceutical care in many areas.

Wha. is pharmaceutical care? Pharmaceutical care has been defined as delivery of drug therapy and attendant drug information to achieve outcomes that improve a patient's quality of life.[2] In essence this addresses pharmacy cognitive services such as providing verbal and written drug information, screening for drug interactions (as Dr. Bastani noted), monitoring for adverse effects, and alerting the physician when the latter two occur. In a nationwide study currently underway at UNMC's College of Pharmacy, Dr. David Scott and I found that pharmacists typically spend more than half their day delivering pharmacy cognitive services yet only 6% had been reimbursed by third party payers.[3] Yet these services have been found to be cost-effective in well-designed studies. In a study of four ambulatory clinics in Chicago, net cost avoidance secondary to pharmacy cognitive services for one year amounted to $221,056.[4] Such a disparity in financial value versus reimbursement cannot be absorbed indefinitely by pharmacies.

I believe pharmacists will continue to deliver pharmacy cognitive service despite the fact they will not be reimbursed for it and are faced with competition from mail-order pharmacies whose primary concern is the drug product and its unit cost. This is because pharmacists possess a professional ethic to render pharmaceutical care. It is questionable, however, that independent pharmacies can remain economically sound without reimbursement for how half of their time is spent. In 1992, there were 31,000 independent community pharmacies; in 1993 there were 25,000.[5] This rate of decline is very concerning. It is not reasonable to assume overloaded physicians can provide the pharmaceutical care lacking due to the growing absence of pharmacies especially in rural areas.

Under the auspices of the Nebraska Drug Information Network, 30 independent community pharmacies in rural Nebraska are documenting their daily activities which will include the pharmacy cognitive services they render, time associated with these activities and attendant cost savings due to their interventions. They will also document how much time and effort they expend in delivering pharmaceutical care for mail order pharmacy customers. With these data we intend to address the concerns expressed by Dr. Bastani, specifically "expenses from treating avoidable side effects, toxicity resulting in hospitalization" and other cost saving measures providing by pharmacists. It is hoped with this information that public policy will change to recognize the value of pharmaceutical care such that pharmacists can continue to deliver pharmaceutical care and serve the public and their physician colleagues.

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ORIGINAL ARTICLE

Three Physician Explorers

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SOME of the most important achievements of physicians have been in fields entirely outside of their profession. These have included writing, art, politics, military leadership, and even professional sports. Silas Wier Mitchell, writer; Sir A. Conan Doyle, the creator of Sherlock Holmes; General Leonard Wood, one time chief of staff and leading contender for President of the United States in 1920; Max Thorek, a leader in pictorial photography and Bill McColl, one time lineman for the Chicago Bears are only a few examples.

High adventure has also attracted physicians and at least three American doctors owe their fame to arctic exploration. One of these, Dr. Frederick Cook was a celebrated explorer at about the turn of the century. Unfortunately, his two great achievements, the discovery of the North Pole and the first ascent of Mount McKinley have been called into question and his claims have been discredited as probably false. Thus, his reputation has become a shadowy one at best, although he still has a few supporters for his discoveries.

No such clouds hang over the names of the other two. Dr. Elisha Kane and Dr. Isaac Hayes belong to the middle of the nineteenth century but they are celebrated among all students of polar exploration and their names remain on geographical features of the far north. Strangely enough, both of them were lured to the Arctic following what seems to us now to be a fantastic dream.

For two centuries, icebergs floating down from the north along the Greenland coast, and birds migrating into the far north had led geographers to believe that beyond the ice pack was a much warmer open sea surrounding the North Pole. If one could penetrate the ice far enough, he could find open water and actually sail to the Pole itself.

Kane also had a much more altruistic incentive driving him to the Arctic. In 1845, the English explorer, Sir John Franklin had led a large expedition north in two vessels - the Erebus and the Terror. Their mission was to find a way to sail through the long dreamed of northwest passage and reach Asia. Franklin's expedition was reported in northern waters beyond Hudson Bay late that summer. Then they vanished and nothing more was heard from them. By 1847 or 1848, public interest over the mystery was aroused and, partly at the instigation of Lady Franklin, repeated expeditions were sent to the Arctic to find the missing explorers or at least to ascertain their fate. By 1850, five years after Franklin had vanished no trace of him had yet been found. Lady Franklin now appealed to the United States Government for aid in the rescue operations.

It was still believed by some that Franklin's party survived locked in by the ice somewhere in the Arctic. Some even believed that they had entered the open polar ocean and were living there blocked from escape by the ice farther south.

Rather reluctantly, the United States agreed to send an expedition into the Arctic to join the search still actively pursued by additional rescue parties, mostly from England. Two vessels, the Rescue and Advance were fitted out and sent north under the command of Lieutenant DeHaven.

Kane at that time was a surgeon in the navy. He had studied medicine at the University of Pennsylvania and graduated eight years before. Elisha Kane came from a remarkable family with a long record of public service and accomplishment. Elisha and his siblings carried on the tradition well. His younger brother, Thomas, had become involved with the cause of the Mormons. While never a Morman himself, his services led to the name of Kanesville

*Reprints request and correspondence to: Edward A. Holyoke, Department of Cell Biology and Anatomy, 600 So, 42nd Street, Omaha, Nebraska 68198-6395.

attached to the Morman encampment near what is now Council Bluffs. Elisha himself was dogged all of his life by chronic illness. From adolescence on, he suffered from recurrent bouts of rheumatic fever and its dreaded complication endocarditis. Perhaps, it was his gloomy prospects for a long life that lead to his love of adventure and his reckless daring. After Kane graduated in medicine, be became attached to the navy and by the time he was thirty, he had traveled over most of the world and survived a long series of desperate escapades some of which he had gone out of his way to encounter. Now stationed in the southern United States at a drab post he was bored by his safe uninteresting life and chafing for further adventure.

Thus, it was that when word of DeHaven's expedition to the Arctic reached him he immediately volunteered to go as surgeon. He was entranced by the idea of more activity and a role in the search for the long lost Franklin. Kane was accepted for the expedition and the way was paved for both his fame and the most daring and perilous adventures of his already adventurous life.

The DeHaven party sailed in May of 1850. They made their way into Baffin Bay, then west through Lancaster Sound between Baffin and Devon Islands. Here, as fortune would have it, they encountered a British expedition and together they stumbled onto the first sign of Franklin that had been found: graves and the remains of a winter camp on what was then known as Beechey Island - since proved to be a peninsula of Devon Island. The expedition became locked in the ice which carried them first north up Wellington Channel and then back into Lancaster Sound. They were forced to winter in the Arctic and after severe privations they managed to free their ships the following spring.

After some fruitless attempts to make their way farther north, the expedition sailed home. The enterprise had been a success in that the entire crew survived and they had found some traces of Franklin's crew. Where Franklin had gone from Beechey Island and what fate had overtaken him remained as cloaked in mystery as ever.

Once home, DeHaven's crew disbanded and DeHaven went on to other assignments. One fling at arctic exploration was enough for him.

Kane however, was completely obsessed with the idea of a return to the North. He was convinced that Franklin had gone north, up Wellington Channel and that there really was an open polar sea. It was his ambition to penetrate into the polar ocean, to prove its existence and to find the Franklin party. He began to work furiously (as furiously as his health would permit) to raise funds and organize his own expedition. All of this was interspersed with an ill advised and fruitless love affair, but the expedition was organized and fitted out and left for the Arctic in the summer of 1853 with Kane in command. One of the crew of the brig Advance was the expedition surgeon Dr. Isaac Hayes.

The details of the expedition have been preserved in Kane's own journal published in two volumes. It is extensively illustrated mostly by drawings made from Kane's own sketches for among other things Kane was a fairly accomplished artist.

After leaving New York, Kane and his party made their way north into Baffin Bay and on to Smith South. Here they encountered the ice pack and continued north mostly by "tracking" literally dragging the ship along by main brute force.

They finally gave up after reaching a point north of the village Etah and the present Thule air force base. They settled down in a sheltered cover for the winter. The brig Advance never left that cove.

Kane made friends with the Eskimos on his way north and while this friendship produced some complications, it also let to sources of supply that may have saved the entire party. The winter was a desperate one. Supplies ran low and worst of all most of the crew became practically incapacitated by scurvy. When spring approached and some fresh meat became available, the crew recovered but they still had one more catastrophic experience.

A detachment had been sent north sledging over the ice. They were beset by some of the worst weather of the entire winter and only a desperate effort by Kane and some of his men rescued them and got them back to the Advance. Two of the crew perished from the effects of that episode.

That summer parties were sent north up Smith sound to explore the hitherto unknown coast and find a possible passage toward the

supposed northern sea. Miles of the unknown coast were charted and explored and one supposedly highly important discovery was reported. One of the crew, William Morton reached a point called Cape Jeferson, as far north as man had ever been. From there, he found open water to the north as far as he could see. The open polar ocean had been discovered and its existence proved. It was some years later that the open water was recognized as a temporary freak of the climate and that the great discovery was an illusion.

More problems however awaited Kane and his men and their worst experiences and most desperate perils were still ahead. The ice imprisoning the Advance did not break up and there was no possibility of getting her free. Fall was rapidly advancing and it became evident that the crew would have to face a second winter in the Arctic.

Half of the expedition refused to accept this verdict and left for the south on their own. The others grimly settled down to endure whatever was in store for them. To make matters worse the party that had gone south returned after terrible hardships in their attempt to escape. That any of the expedition survived that second winter of privation and disease (mostly scurvy again) is something of a miracle. It is possible that only occasional visits from the Eskimos with bits of fresh meat kept them alive.

When spring finally came, only one hope remained - to abandon the Advance and try to escape to the south with sledges and open boats. That terrible journey of over 500 miles lasted for 85 days of incredible dangers, hardship and exertion but the party finally made it to the Danish village of Upernavak. Here just as they were about to embark on a ship bound for Denmark, a rescue vessel from the United States arrived. Safe at last the expedition made its way home after two years in the Arctic.

Kane was welcomed home as a national hero and his reception everywhere can be compared only to that accorded celebrities like Charles Lindberg some seventy years later.

Kane plunged into the monumental task of writing up his journal for publication and meeting the demands made on him as a celebrity.

During his years of extreme exertion and hardship in the Arctic, his rheumatic fever and endocarditis subsided and he endured the stress as well as the hardiest of his crew. Now in a temperate climate his illness flared up again. He became an invalid and eventually suffered from repeated strokes - probably due to emboli from his endocarditis. Finally in 1857, two years after his return, he died at the early age of 37. Few even among the hardiest and most daring ever crowded as much adventure, peril and hardship into much longer lives.

Dr. Isaac Hayes, the surgeon of Kane's expedition, later led two parties of his own into the far north. Hayes, like Kane was convinced of the existence an the open polar sea. Like Kane he too failed to reach that objective.

Ironically, both of the dreams that drove these two great physician explores north turned out to be illusions. Kane's theory that Franklin had gone north, up Wellington Channel had been proved wrong by the time that Kane reached home. Franklin had actually gone west and south from Beechey Island. A thousand miles from where Kane had expected to find him, his vessels had been wrecked in the ice near King William Island and the entire expedition had perished trying to reach the Canadian mainland.

Hayes lived to see the dream of the open polar sea shattered although Kane was probably spared this. The later expeditions of Charles F. Hall, George Nares, A.W. Greeley and others proved that the Arctic Ocean is ice locked everywhere and only a freak shift in the current had produced the open water seen by Morton years before.

Still the records of Kane and Hayes as explorers stand. Both names are on the map. Kane Basin, north of Baffin Bay, and Hayes Peninsula, on the northern Greenland coast, are there for all who look at the maps to read.

The way to the far north Arctic Ocean had been found for those who followed, Nansen of Norway, the Duke DiAbruzzi of Italy and finally Robert E. Peary who was to reach the Pole itself.

To us in medicine today, one great mystery remains. How could Kane's crew have been permitted to be devastated by scurvy during both of his winters in the north? While the real

cause of scurvy awaited the discovery of vitamins many years later, the British already knew that a constant diet of salt pork lead to scurvy and that lime juice would prevent it.

The British expeditions had long been free from scurvy and still the Americans were plagued by it. Kane's experiences were not alone. Years before (1819-1820) the American encampment at what was then known as Cantonment Missouri (Nebraska), (Later, Fort Atkinson and still later, Fort Calhoun) had been decimated by scurvy. This question can not be answered today. All we can do is admire the courage of those who endured the consequences and managed to survive.

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ORIGINAL ARTICLE

Hypersensitivity To Therapeutic Murine Monoclonal Antibodies

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OBJECTIVE: To determine the predictive value of pre-treatment skin tests and in vitro IgE/IgG_4 anti-murine monoclonal antibodies in patients treated with murine monoclonal antibodies.

Design: Patients treated at two cancer institutions were evaluated by skin testing and solid phase immunoassays to detect IgE and IgG_4 specific anti-murine monoclonal antibodies. Skin testing by scratch and intradermal skin testing was done on patients before treatment with murine monoclonal antibodies. IgE & IgG_4 specific anti-murine monoclonal antibodies were determined before treatment in all patients and at 1, 7, 14 and 21 days post-treatment in 1 patient.

Setting: Cancer patients undergoing murine monoclonal antibody treatment in two university medical centers were recruited for the study.

Participants: Twelve patients, aged 41-75 years with gastrointestinal cancers (colon, stomach, pancreas or liver) with metastatic disease, who had relapses or conventional therapy were enrolled. Some patients had previous exposure to rodents, either as laboratory personnel or had kept them as pets.

Intervention: One patient who experienced an anaphylactic reaction to murine monoclonal antibody infusion was desensitized so therapy could continue.

Main outcome measures: Skin tests, immunoassays, and patient history were correlated with adverse reactions to infusions of murine monoclonal antibodies.

Main results: Skin tests (scratch method) and/or in vitro immunoassays may predict allergic outcomes in patients receiving infusions of murine monoclonal antibodies. Intradermal skin testing with murine monoclonal antibodies may result in false positive reactions and have less predictive value. Specific IgE or IgG_4 were elevated in the two patients who experienced severe adverse reactions to murine monoclonal antibodies but not in those patients with no reactions and therefore, may have some predictive value. A history of past exposure to mice may also increase the risk of adverse reactions. In one patient, intravenous desensitization enabled treatment to proceed.

Conclusion: Scratch skin tests, in vitro IgE and/or IgG_4 immunoassays together with a past history of previous exposure to murine antigen(s) may predict potential allergic reaction to therapy with murine monoclonal antibodies.

Significant progress has been made in utilizing hybridoma technology to develop monoclonal antibodies (MAb) that recognize human tumor antigens. These include MAb against melanoma, lymphoma, acute lymphoblastic leukemia, solid tumor cells including neuroblastoma and gastrointestinal carcinomas[1-6] and pancreatic cancer.[7,8] Murine MAb have been used both for diagnosis and treatment, alone or conjugated with cytotoxic agents.[9-11] Although not all are in agreement,[12] the increasing use of mice as a source of MAb may result in hypersensitivity towards murine proteins. Additionally, direct cytotoxic effects by MAb on normal cells can occur.[12, 13]

The purpose of this study was to determine whether pre-treatment skin tests and specific IgE and/or IgG_4 anti-murine antibodies may be of value in predicting the occurrence of allergic reactions caused by treatment with murine MAb.

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Materials and methods

Serum was obtained from twelve patients, ages 41-75, with gastrointestinal carcinomas (colon, stomach, pancreas, or liver) who were treated with various murine MAb (Table 1). All patients had metastatic lesions which were unresponsive to conventional therapy. Details of the MAb preparations and clinical features of most of these patients were reported elsewhere.[3,8] A complete allergy history followed by skin testing on each of the patients was performed by one of the authors (AS). Three antigens were used: Commercial mouse epidermal antigen (MEA, Hollister-Stier), and the two MAb-A and -B agents used in the treatment of these patients (Table 2). Four patients were treated with MAb-A (Column 1) and seven with MAb-B (Column 2). Both MAb were directed against gastrointestinal carcinoma-associated antigens. The MAb were given intravenously in increasing doses over five days. Blood samples were collected from most patients prior to treatment and 72 hours after completion of therapy. All patients were monitored for allergic reactions throughout the treatment period.

TABLE 1
TYPE OF CANCER AND MONOCLONAL ANTIBODY TREATMENT IN ENROLLED PATIENTS.

PATIENT #	SEX	AGE	TYPE OF CANCER	TYPE OF MAB
1	M	51	Esophagus	B
2	M	55	Pancreas	B
3	M	69	Pancreas	B
4	M	53	Gastroesophageal	A
5	F	41	Colon + Liver	A
6	M	74	Gastric	B
7	F	62	Colon + Liver	A
8	M	53	Colon	B
9	M	53	Colon + Liver	B
10	F	75	Colon	A
11	F	34	Pancreas	B
12	F	63	Pancreas	C

TABLE 2
SKIN TEST SCHEDULE EMPLOYED

I. Scratch Tests (performed initially)
   1. Mouse epidermal skin test antigen (MEA) 1:20 w/v
   2. Monoclonal antibody (MAB) undiluted
   3. Controls (Histamine, Saline)

II. Intradermal Tests (performed only if scratch tests are negative)
   1. MEA 1:1000
   2. MEA 1:100
   3. MEA 1:10
   4. MAB 1:100
   5. MAB 1:10
   6. MAB undiluted
   7. Controls (Histamine, Saline)

Prior to treatment with MAb, both prick (1:20 dilution; undiluted) and intradermal skin tests (increasing ten-fold dilutions beginning with a 1:1,000 dilution) were performed on the first ten patients using each of the three antigens. In addition, serum samples were tested for antibody against murine antigens by laboratory personnel who were unaware of the patients' clinical course. Solid phase radioimmunoassay was performed using cyanogen bromide activated cellulose discs coated with MAb-A, MAb-B, or MEA. Each patient's serum was added separately to three different discs coated with these antigens. I^{125} labeled rabbit anti-human IgE heavy chain was then added and unbound labeled antisera washed away. The percentage of I^{125} bound by the discs was determined, reflecting the amount of patient IgE antibody to murine MAb. A similar technique was used to determine IgG^4 antibodies to MAb. Specific IgE and IgG_4 antibody values of reach patient were compared with that of pooled serum of healthy laboratory workers and with a buffer solution (negative control). Results were expressed as the percent of labeled anti-IgE or anti-IgG_4 antibody bound by the serum sample divided by the percent bound by buffer. Following completion of the assays, the code was broken and details about each patient were revealed.

Results:

Skin Tests (Table 3). Four patients had negative pre-treatment prick and intradermal skin tests. Six had negative pre-treatment prick tests but varying degrees of positive intradermal tests when tested with undiluted MAb. Four of the six also had a positive intradermal test for MEA at a weight per volume concentration of 1:100. All patients had positive histamine control tests. None of the patients 1-10 had clinical evidence of an allergic reaction during the 5-day course of treatment.

Patient #11, who was not tested before treatment, developed pruritus, urticaria, abdominal cramps, nausea, and diarrhea within minutes following initial administration of the MAb. She was not skin tested until 24 hours after the first infusion of MAb. At that time, she had a strongly positive prick test with both MEA and the MAb used for treatment. She previously had worked as a research technician and had been exposed to mice but had no known adverse reaction to murine antigens prior to her first MAb treatment.

Specific Antibodies. Specific IgE and IgG_4 antibodies to MAb-A were markedly elevated in the serum of patient #11, (Figure 1 and Table 4). Her levels were more than three standard deviations (S.D.) above the mean level of the other patients. A similar finding was noted with regard to specific IgE and IgG_4 antibodies to MEA. She also had high levels of specific IgE against MAb-B, but IgG_4 antibody levels to this antigen was not significantly elevated because of the large standard deviation caused by one skin test negative patient who had high IgG_4 antibodies to MAb-B. She was not treated again with MAb due to the severity of her reaction.

The six patients with positive intradermal tests are represented by open circles in Figure 1. Their antibody levels were all within 2 SD of the mean. The pooled serum of lab workers (control serum), some of whom had worked with mice, had a value close to the mean value of the unaffected patients. A serum specimen obtained 72 hours after the single infusion of MAb from the patient with anaphylaxis (#11) revealed persistently high levels of specific IgE and IgG_4 antibodies. IgG_4 antibodies against MAb-B (not used in treatment of this patient) were elevated to a lesser degree.

Serum from another patient (#12) who had a severe allergic reaction to MAb was subsequently received for evaluation. As this case illustrates certain interesting points, it is presented in detail.

Case #12: This was a 63-year-old white female with adenocarcinoma of the pancreas with pulmonary and subcutaneous metastases. She was referred to skin testing against murine proteins prior to therapy with a third MAb, designated 17-1A of the IgG_{2a} isotype.[8] She had poor response to prior chemotherapy (5-FU, adriamycin, and mitomycin) and there was progressive growth of a tumor nodule in the scar of a previous laparotomy. Prior illnesses included a long history of atopy and asthma with numerous allergic reactions to environmental agents (animal dander, dust, wool, feath-

TABLE 3
RESULTS OF SKIN TESTING 9mm ERYTHEMA/MM WHEAL WITH TREATMENT MONOCLONAL ANTIBODY (MAb) AND MOUSE EPIDERMAL ANTIGEN (MEA)

PATIENT	SCRATCH TEST		INTRADERMAL TEST				REACTION TO IV MAB
	MEA	MAB	MEA		MAb		
	1:20	Undiluted	1:1000	1:100	1:100	Undiluted	
1-4	0	0	0	0	0	0	(-)
5	0	0	0	6x7/6x7	0	15x18/10x10	(-)
6	0	0	2x2/2x2	5x5/5x5	0	6x5/6x5	(-)
7	0	0	0	5x5/5x5	0	5x5/5x5	(-)
8	0	0	0	35x40/5x5	0	5x5/1x2	(-)
9	0	0	0	0	0	12x12/12x12	(-)
10	0	0	0	0	0	15x20/7x10	(-)
11	20x22/5x6	20x25/8x6	ND	ND	ND	ND	(+)[1]
12	0	0	ND	ND	0	ND	(+)[2]

[1] Anaphylactic reaction. Infusion discontinued and no further treatment given.
[2] Systemic reaction with wheezing and hives. Patient "desensitized" and treatment continued and completed.

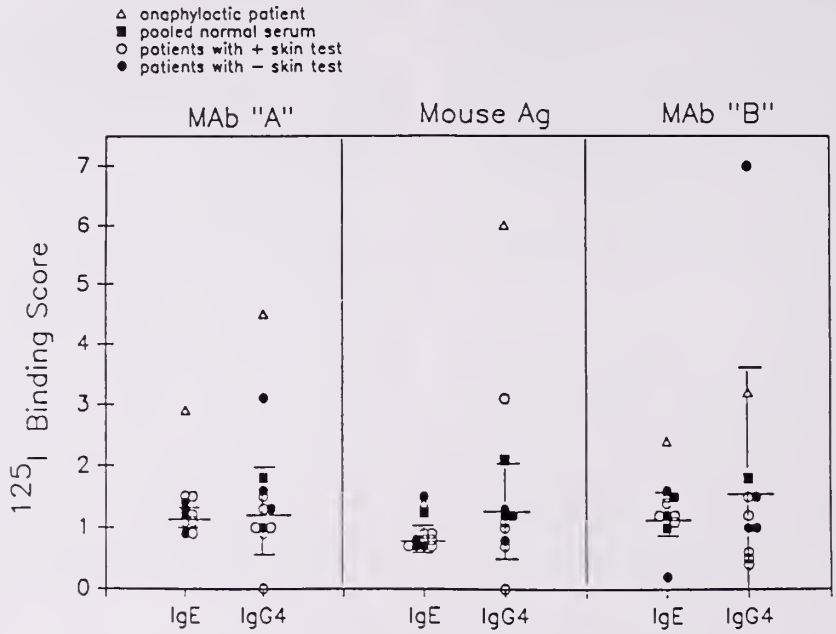
TABLE 4
BINDING OF SERUM IgE AND IgG4 TO DISC COATED WITH MAb "A", MAb "B" AND MEA
(cpm ^{125}I anti-IgE or anti-IgG4 bound by serum/buffer)

Serum	IgE			IgG4		
	MAB "A"	MAb "B"	MEA	MAb "A"	MAb "B"	MEA
Pooled serum, lab workers	1.2	1	1.25	1.8	1.8	2.1
Patients 1-10, pre-treatment	1.2 ± 0.2	1.2 ± 0.4	0.9 ± 0.2	1.3 ± 0.8	1.6 ± 1.9	125 ± 0.8
Patient 11, 4 hrs. post -RX	2.9	2.4	1.4	4.5	3.2	6.0
	Homo[1]	Heter[2]	MEA	Homo[1]	Heter[2]	MEA
Patients 1-10, 2 hrs. post-RX	1.4 ± 0.3	1.2 ± .03	0.8 ± 0.3	1.7 ± 1.3	1.4 ± 0.7	.6 ± 0.9
Patient 11, 2 hrs. post-RX	3.9	2.4	1.7	4.3	2.5	6.1

Homologous = the same MAb used for therapy and for radioimmunoassay for patient 11
Heterologous = different MAb used for therapy and for radioimmunoassay for patient 11

FIGURE 1

^{125}I Binding Score of IgE and IgG_4 in tested sera, to discs coated with the monoclonal antibodies (MAB) or mouse epidermic skin test antigen.



ers), penicillin, and sulfa. Both she and her children kept pet mice in the past. Other health problems included hyperglycemia and past operations included a hysterectomy, tonsillectomy, and adeniodectomy. She was taking albuterol by metered dose inhaler, Theodur-SR™, Metamucil™, Surfak, and various vitamins. Physical examination at the time of referral revealed vital signs to be normal. There was no icterus or adenopathy. There were rales and bronchial breath sounds at the right base. A palpable epigastric mass and a nodule in a cholecystectomy scar were identified. Her liver measured 16 cm in the midclavicular line and the left lobe extended 12 cm below the xiphoid cartilage. The remainder of the examination was unremarkable. Skin testing with 1:1000, 1:100 and 1:10 of MAb (1:10 dilution - 1.0 mg/ml) were carried out by both prick and intradermal testing. These were negative. Skin tests to mouse protein dander were also negative. A histamine control was positive (Table 5).

Following the negative skin testing, the patient was admitted to the hospital for treatment. During the initial infusion of antibody, she began to complain of dyspnea, chest tightness, and flushing. Examination showed her pulse to be 120, blood pressure 150/86, and diffuse wheezing appeared. The infusion was stopped and the patient responded well to epinephrine and Benadryl. Since the patient wished to continue treatment with MAb, she was moved to the intensive care unit of MAb desensitization before proceeding with further treatment. An aminophylline drip was started in another vein and was continued throughout the procedure. Under close monitoring, she was given incremental infusions of a dilute solution (1:1,000) of MA 17-1A over a 4-hour period until a total dose of 5 mg had been reached. She remained normotensive with a normal pulse rate throughout the procedure although she did have a sensation of chest tightening and an erythematous rash which was relieved with Benadryl. She was maintained on an IV drip of dilute antibody (1:1,000) at the rate of 10 mg per hour throughout the remainder of her hospitalization. She had no further problems with treatment and received a total dose of 450 mg of antibody. Pre- and post-treatment (0, +1, +2, +3, and +4 weeks) sera were tested for specific IgE and IgG_4 antibodies to MEA and the two MAb used in previous study (Table 5). The results demonstrated:

A. Normal pre-treatment serum levels of specific IgE antibody to MA 17-1A with a marked elevation one week after treatment with MAb.

B. Very high pre-treatment serum levels of IgG_4 antibody against all murine antigens tested, with even higher levels one week post-treatment.

TABLE 5
IgE AND IgG4 ANTIBODIES OF PATIENT 12 to MAb "A", MAb "b" AND MEA
(cpm ^{125}I anti-IgE or anti-IgG4 bound by serum/buffer)*

	IgE			IgG4		
	MAb "A"	MAb "B"	MEA	MAb "A"	MAb "b"	MEA
Pooled sera, lab workers	1.2	1	1.2	1.8	1.8	2.1
Patient 11, 1 day post RX	7.3	6.1	3.1	4.3	4.3	6.1
Patient 12, Pre-RX	1.5	1.1	1.2	23.8	21.1	46.7
Patient 12, Post-RX 1 day	1.2	1.5	2.2	23.3	20.0	49.4
Patient 12, Post-RX 7 days	11.9	11.2	1.7	37.6	33.9	53.6
Patient 12, Post-RX 14 days	2.9	2.5	1.4	31.6	26.5	46.0
Patient 12, Post-RX 21 days	2.3	1.5	1.7	20.3	21.5	43.4
Patient 12, Post-RX 28 days	1.9	1.4	1.3	24.0	22.8	47.3

*These assays were carried out several weeks after the assays indicated in Table 4. A freshly labelled anti-IgE reagent resulted in higher IgE binding for patient 11 in the later assays. Note the peak IgE responses of patient 12 seven days post-infusion and the return to pre-infusion levels by 3 to 4 weeks.

Discussion

The recent advent of murine MAb has made specific antitumor antibodies available for experimental treatment protocols. However, the widespread use of these foreign proteins carries a definite risk of untoward effects. Dillman, et al[12] recently described hypersensitivity reactions including anaphylaxis, bronchospasm, urticaria, and pruritus in 18% of patients treated with MAb.

Some investigators have questioned the predictive value of skin tests, IgE antibody levels, or other immunologic indicators for allergic reactions. In Dillman's study, skin tests were not performed on most of the patients because of equivocal results during prior prospective testing of patients. Unfortunately, a lack of confidence in skin tests as well as *in vitro* antibody studies may cause these tests to be omitted prior to therapeutic use of MAb. Our results demonstrate that carefully performed skin and/or immunologic tests, if positive, might predict an allergic reaction. We believe skin tests should be carried out prior to treatment with murine MAb since a significant percentage of recipients will experience allergic reactions of varying degrees of severity. When positive, skin tests indicate the need for caution, or "desensitization" prior to therapeutic administration of the MAB. Prick or scratch skin tests with both MEA and the MAb used for treatment are recommended for the screening of patients who are to receive murine MAb. Intradermal tests with MEA at a dilution of 1:100 can result in false positive reactions and these have limited predictive value. Likewise, intradermal testing with undiluted MAb resulted in positive reactions, but no allergic consequences. Thus, prick tests beginning at 1:100 dilution, then 1:10, and finally full strength are recommended. If these are negative, they may be followed by immunochemical tests for IgE and IgG_4 anti-MAb antibodies. If the latter are positive, the clinician is forewarned about potential allergic reactions.

In a few hypersensitive patients, skin tests may be negative, perhaps due to decreased dermal reactivity as has been described in some cancer patients.[14] Antihistamines should be avoided for three days to three weeks prior to the skin tests, depending on the half life of the antihistaminic agent. In these cases, pretreatment levels of IgE and/or IgG_4 specific antibody may provide an important clue of hypersensitivity as was demonstrated by patient 12. Interestingly, the pre-treatment IgE anti-MAb serum level in this patient was negative, a finding which correlated to the negative skin test. There is little evidence that IgG_4 antibodies are involved in immediate type skin reactions although it has been noted that high levels of IgG_4 antibodies are more common in allergic than in non-allergic patients.[15-17] Thus, elevated levels of IgG_4 antibodies may portend a vigorous immune response and warn of a potential severe, adverse reaction. That elevated specific IgG_4 antibodies per se' occasionally act as "anaphylactic" antibodies is yet to be proved. Nevertheless, patient 12 had elevated IgG anti-MAb and experienced a systemic reaction.

Although an elevated IgE specific antibody level is undoubtedly of greater clinical significance than elevated IgG_4 antibody, the latter

does indicate prior exposure to the allergen in question. Thus, the combination of a careful history indicating prior exposure to MAb or contact with rodents, evidence of an allergic background, together with positive skin tests and IgE and IgG_4 anti-MAb antibodies provide some basis of deciding whether desentitization and/or prophylactic antiallergic medications are indicated in patients receiving therapy with murine monoclonal antibodies. Patient 12 demonstrated, that despite the occurrence of a systemic reaction, administration of MAb is possible after desensitization. This preliminary study suggests the need for more extensive evaluation of potential predictors of adverse reactions due to therapeutic administration of murine MAb.

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ASK A LAWYER

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1. What is the physician-patient privilege?

The physician-patient privilege is a legal shield which allows a patient to prevent the disclosure of confidential communications which occur between the patient and doctor regarding the patient's physical, mental or emotional condition. Neb. Rev. Stat. § 27-504 (Supp. 1993). A confidential communication that occurs in the presence of other health care providers or family members is also protected by the privilege. A communication is confidential and therefore protected by the physician-patient privilege if it furthers the interests of the patient or others involved in treatment and was not intended to be revealed to anyone not present during the communication.

2. Who may invoke the physician-patient privilege?

The privilege may be claimed by the patient, the patient's guardian or conservator, or the personal representative of a deceased patient. The physician may claim the privilege on behalf of the patient, and it is presumed that the patient has authority to claim the privilege unless there is evidence to the contrary. Neb. Rev. Stat. § 27-504 (Supp. 1993).

3. Are there certain types of communications not protected by the physician-patient privilege?

Yes Neb. Rev. Stat. § 27-504 provides that the physician-patient privilege cannot be invoked to prevent the disclosure of:

a. communications relating to proceedings to hospitalize the patient if the physician deems it necessary;

b. communications concerning the condition of the patient in a proceeding where the patient has relied on that condition as an element of the claim for relief;

c. communications regarding injuries to children, incompetents, or disabled persons which are required for adjudication of a juvenile court proceeding; and

d. communications concerning an attempt to obtain a controlled substance.

In addition, other statutes suspend the privilege and require disclosure in judicial proceedings concerning child abuse. Neb. Rev. Stat. § 28-714 (Supp. 1993), wounds caused by violence Neb. Rev. Stat. § 28-902 (Reissue 1989), and workers' compensation injuries Neb. Rev. Stat. § 48-120 (Supp. 1993).

***

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FEBRUARY 11, 1995 — Management of Colon and Rectal Diseases by the Primary Care Physician, Marriott Hotel, Omaha, NE.

MARCH 23, 1995— Distinguished Lecture Series - James N. Baraniuk, M.D. - Boys Town National Research Hospital Auditorium, Omaha, NE.

MAY 6-7, 1995 — Anesthesiology Conference, Marriott Hotel, Omaha, NE.

MAY 26-28, 1995 — Family Medicine Update, Village East Resort, Okoboji, IA.

If you have any questions, please contact: Sally C. O'Neill, Ph.D., Associate Dean, Creighton University CME Division, 601 North 30th Street, Suite #2130, Omaha, NE 68131.

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REPORTS OF OFFICERS, DELEGATES, COMMISSIONS AND COMMITTEES

FALL SESSION
SEPTEMBER 15-17, 1994

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports.)

REPORT OF THE BOARD OF DIRECTORS

Frederick F. Paustian, M.D., Omaha - Chairman; David L. Bacon, M.D., Kearney; Christopher C. Caudill, M.D., Lincoln; Charles F. Damico, M.D., Hastings; Herbert A. Hartman, Jr., M.D., Omaha; Ronald W. Klutman, M.D., Columbus; Darroll J. Loschen, M.D., York; David R. Little, M.D., Hastings; Richard H. Meissner, M.D., Omaha; Robert G. Osborne, M.D., Lincoln; Robert F. Shapiro, M.D., Lincoln; Scott A. Shipman, Omaha.

The Board of Directors has met on three occasions subsequent to the 1994 Annual Session and presents this report to the House of Delegates for its consideration and approval.

1. RESOLUTION #1 (A94) SUPPORT FOR MEDICAL SERVICE ACCOUNT FORMAT FOR HEALTH SYSTEM REFORM

The NMA House of Delegates adopted this resolution which called on the Association to express strong support for the medical service account concept with reimbursable tax credits, and directed the Association leadership convey this support to the AMA House of Delegates' 1994 June Meeting and to the Nebraska Congressional delegation. This resolution was forwarded to the AMA House of Delegates who adopted a recommendation that the AMA Board of Trustees continue to implement AMA policy to achieve universal access and coverage through an approach that may utilize employer and/or individual responsibilities for payment, while permitting the individual to choose and own his or her health insurance plan. In addition, the Board of Trustees should continue to encourage health IRAs, a coverage phase-in mechanism, and explore all concepts that accomplish coverage for and access to health services for all Americans while recognizing the needs of individual states. Finally, the Board of Trustees is directed to report back to the House on its efforts at the 1994 Interim Meeting.

2. RESOLUTION #2 (A94) IMPROVEMENT IN REIMBURSEMENT FOR PRIMARY CARE SERVICES IN RURAL AREAS

The House adopted this resolution which directed that the NMA and the AMA study reimbursement of rural primary care services in general, and reimbursement for primary care services under the RBRVS. A resolution was submitted to the AMA House of Delegates for consideration at its June 1994 meeting and it was adopted. In addition, the NMA Board of Directors considered a statistical comparison of Medicare reimbursement between Nebraska physicians and Kansas physicians and the NMA Ad-Hoc Committee RE: Medicare directed a letter to the Health Care Financing Administration requesting that the issue of Medicare reimbursement to Nebraska physicians be studied and addressed. The letter to HCFA also requested that the proposed rules carried in the July 24, 1994, issue of the Federal Register, concerning RBRVS reimbursement for 1996, be considered in more detail as there is a proposed further disparity of Medicare reimbursement for Nebraska physicians when compared to several surrounding states. A copy of this correspondence was provided to each member of Nebraska's delegation. The Ad-Hoc Committee Re: Medicare and the Board of Directors will continue to be involved in this issue.

3. RESOLUTION #3 (A94) ANY WILLING PROVIDER LEGISLATION, RESOLUTION #10 (A94) WILLING PROVIDER AND PATIENT FREEDOM OF CHOICE, RESOLUTION #13 (A94) WILLING PROVIDERS

The House of Delegates combined these three resolutions into one which proposed that the Association have legislation introduced in the 1994 Unicameral which will provide for patient freedom of choice in choosing their physician and that the Association begin immediately to find other organizations and patients who are willing to contact their state senators and testify at legislative hearings in favor of a patient freedom of choice bill. The Board asked that the NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems consider this resolution and that it provide the Board with input on this matter. In addition, the resolution will be considered by the Commission on Legislation and Governmental Affairs when it meets in coming weeks.

4. RESOLUTION #4 (A94) BREAST CANCER EDUCATION

This resolution was sent to the Commission on Legislation and Governmental Affairs inasmuch as it proposed that the Association study legislation from other states which pertains to informing breast cancer patients of alternative efficacious methods of treatment including surgical, radiological, hormonal or chemotherapeutic treatment or combinations thereof. The resolution was also forwarded to the Commission on Public Affairs inasmuch as there was a directive that the Association work with the Department of Health to develop a booklet which explains the alternative medically acceptable methods of treating breast cancer.

5. RESOLUTION #5 (A94) PHYSICIAN EDUCATION, BREAST CANCER

This resolution was referred to the Commission on Public Affairs as it directed that the Association work with the Nebraska Department of Health to develop appropriate professional continuing medical education to facilitate the diagnosis of breast cancer.

6. RESOLUTION #6 (A94) DUES INCREASE

This resolution directed that the Association only implement dues increases after carefully examining finances with the House of Delegates determining that a dues increase is an absolute must. It was noted that the Board carefully evaluates the need for dues increases in order to meet the operating expenses. The Annual Session Reference Committee noted that the resolution received favorable testimony and appears to be a reaffirmation of the existing approach to determining dues for the NMA membership.

7. RESOLUTION #7 (A94) COST OF SUBPOENAED RECORDS

This resolution called on the Association to inves-

tigate the cost of actually submitting medical records to the court and directed that the Association work with state senators to introduce legislation that would reflect the true cost of submitting records to the court system. This resolution was referred to the Board of Directors which was instructed to see if a common ground could be found between the leaders of the Association and the leaders of the Bar Association. The Board has determined that its Executive Committee should meet with representatives of the Nebraska Bar Association to determine what action needs to be taken to resolve this issue.

8. RESOLUTION #8 (A94) RESIDENCY HOUSE OFFICER NMA REPRESENTATION

This resolution directed that if an unaffiliated residency program has 100% membership in the Nebraska Medical Association, they be allowed one house officer seat in the NMA House of Delegates. The resolution was adopted by the House of Delegates and referred to the Commission on Association Affairs for the development of proper wordage to implement the necessary bylaw change. The following bylaw amendment was developed and is presented to the House of Delegates for approval:

> "CHAPTER VI, SECTION 7. A minimum of four delegates representing the House Officer Staff Association shall be entitled to hold voting membership in the House of Delegates. No less than two of these delegates shall be elected from the Creighton University House Staff Association and no less than two of these delegates shall be elected from the House Officers Association of the University Medical Center. Provided further that if the membership of either house staff association exceeds 50 members, then such association shall be entitled to one additional delegate for each 50 members or major fraction (50%) thereof. Such individuals must be current dues-paying members. <u>In addition, if an unaffiliated residency program has 100% membership in the Nebraska Medical Association, it will be provided one House officer seat in the House of Delegates.</u> House officer members shall not be considered members of a component county medical society for the purpose of determining the number of delegates to which a component county medical society is entitled."

9. RESOLUTION #11 (A94) RETIRED PHYSICIANS VOLUNTEER EFFORTS

The House referred this resolution to the Board which called on the Association to complete negotiations with the St. Paul Company to allow retired physicians to purchase malpractice insurance coverage at a reduced rate in order to volunteer and provide services in homeless shelters and so forth. The St. Paul Company's filing with the Department of Insurance was approved and the coverage is now available. Medical Liability Mutual and The Medical Protective Company were informed of the Department of Insurance action and both companies are now studying the possible provision of similar coverage.

10. RESOLUTION #12 (A94) APPROPRIATE MEDICAL CARE DECISIONS

This resolution was adopted by the House of Delegates. It called on the Association to investigate the practice of insurance companies making medical decisions remote from patients and directed the Association encourage insurance companies to refer to care they choose not to reimburse as cost/benefit based instead of care which is inappropriate. This resolution was referred to and is currently being considered by the NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems.

11. RESOLUTION #14 (A94) PROHIBITION OF SMOKING IN PUBLIC PLACES

This resolution called on the Association to support state and federal initiatives to ban smoking in public places, especially health care facilities. The Association will utilize this position of the House of Delegates as state and federal legislation and/or regulations are considered.

12. RESOLUTION #15 (A94) NMA GROUP HEALTH INSURANCE CARRIER

This resolution directed that the Association Board of Directors, in its annual review of the group health insurance contract, keep provider/insurer relationship concerns in mind and instructed that the NMA President appoint a committee to work with third party payors on those concerns of mutual interest that adversely impact patient-physician relationships. This resolution was referred to the newly appointed NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems for consideration, and matters of concern were presented to the NMA group health insurance carrier when the renewal for the next policy year was considered.

13. RESOLUTION #16 (A94) NEBRASKA DEPARTMENT OF SOCIAL SERVICES MANUAL AND CO-PAYMENT SCHEDULE

When considering this resolution, the House adopted the portion which recommended that the Nebraska Department of Social Services designate primary care services provided by obstetricians and gynecologists a primary care specialty in their co-payment schedule. This issue was referred to the Ad-Hoc Committee on Medicaid Services and discussion regarding this issue took place with representatives of the Department. After further consideration of this issue by the NMA Board, it took action reaffirming that, for Medicaid co-pay purposes, the NMA position continued to be that OB/GYN should be included as a primary care provider of service. A second recommendation regarding the resolution was referred to the Board for consideration. This matter dealt with proposing that the NMA recommend that the Department of Social Services designate primary care services provided by any M.D./D.O. be exempt from the co-pay. The Board referred this recommendation to the Ad-Hoc Committee on Medicaid Services for its review. It was the opinion of the Board that the AMA House of Delegates' newly developed definition of primary care would come into play in this regard. The Ad-Hoc Committee on Medicaid Services continues to consider this issue and the AMA definition of primary care will be presented to the House of Delegates for its ratification in another section of this report.

14. RESOLUTION #17 (A94) PHYSICIAN DIRECTED MANAGEMENT SERVICE ORGANIZATION

This resolution empowered the Board of Directors to proceed expeditiously to study the value and benefit of establishing a medical service organization either directly or indirectly, and that the Board report back to this session of the House of Delegates on its findings. The President of the Association contacted each NMA councilor and requested information on existing or planned physician organizations of any category within their district. The information provided was rather limited and it was determined that a meeting of physicians directly involved in various structures being considered or underway should be invited to attend a meeting. The anticipated attendance on the initial date selected for the meeting did not appear to be sufficient to proceed, consequently, an alternate meeting date must be considered. The Board will continue to address this matter and inform the House of the information that it accumulates.

15. RESOLUTION #18 (A94) TOLL FREE NUMBER FOR MEDICARE PATIENTS' COMPLAINTS REGARDING DECISIONS OF SUNDERBRUCH CORPORATION

This resolution called on the Association to consider establishment and publication of a toll free telephone number that Medicare patients or their physicians could call to report situations in which decisions of the Sunderbruch Corporation result in denial of reimbursement for legitimate services or instances in which patients are informed that continued care is not reimburseable under the Medicare program. The Board considered this matter in depth as did the NMA PRO Overview Committee and it was determined that it was not financially feasible for the Association to provide a toll free line for this purpose. The Board had previously considered whether to implement a toll free line for general use purposes by members of the Association, and possibly by the public, and had determined that the provision of this telephone access was also not financially feasible. The PRO Overview Committee did meet with Sunderbruch representatives as instructed by the House of Delegates for purposes of discussing the areas of concern.

16. DEFINITION OF PRIMARY CARE

The House of Delegates of the American Medical Association has spent a considerable amount of time defining primary care. During its deliberations in June, 1994, the AMA House of Delegates adopted a definition. The NMA Board of Directors herewith presents the AMA definition, with a minor addition, for consideration by this House of Delegates with the recommendation from the Board that it be adopted. The definition is as follows: "That NMA policy state that primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, curative, counseling, and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a physician (M.D./D.O.) over time. Care may be provided to an age specific or gender specific group of patients, as long as the care of the individual patient meets the above criteria."

17. AMA LEADERSHIP CONFERENCE

The AMA had originally scheduled its 1995 National Leadership Conference to take place in conjunction with the Interim Session of the AMA House of Delegates in December, 1995. Recently, the AMA determined that the 1995 Conference will take place April 23-26 in Washington, D.C. This change in scheduling makes it necessary that the NMA House of Delegates elect, during this Fall Session, the NMA member who is to attend the conference as a recognition of involvement by the member in NMA activities. This is the activity in which an Association member is recognized for his/her activities at the state level by being given the opportunity to observe the National Leadership Conference which is produced annually by the American Medical Association. The NMA House of Delegates had previously determined that the selection of the nominee will be on a rotational basis, which for the 1995 conference would provide that a representative from Lancaster County be elected. This matter has been placed on the agenda for the House of Delegates.

The Board is concerned that the April scheduling of the Leadership Conference will continue, on an annual basis, to conflict with the Annual Session dates of the Nebraska Medical Association and possibly other state medical associations. This being the case, the Board asked that Darroll J. Loschen, M.D., as an AMA Delegate, and the Nebraska delegation to the AMA, address this matter with the possibility that a resolution be prepared for the AMA House of Delegates, and for consideration by the North Central Medical Conference.

18. MEMBERSHIP

The Board of Directors and the county medical societies continually strive to increase total membership. The Board monitors member and non-member lists and makes contacts to augment the mailings which invite membership in the Association. The Association has gained 99 new members in 1994. In addition, 5 former members have been reinstated. There are currently 1,606 dues paying members of the Association and 271 Life & Associate members. Our total membership is 1,878 which comprises 64.2% of Nebraska's 2,924 physicians. The Association continues to experience an increase in total membership each year. Attached to this report are membership figures for the Association designated by county. It is imperative that members of the House of Delegates and all Association members encourage their non-member colleagues to join the federation of medicine as we face continual change in the health care system.

19. NMA BLUE CROSS/BLUE SHIELD GROUP HEALTH INSURANCE PLAN

The Board is pleased to report that the NMA endorsed Blue Cross/Blue Shield health insurance plan has experienced a highly successful financial year and there will be no rate increase for the next policy year which begins on October 1, 1994. The financial success of the program is discussed in detail in the finances item of this Board report.

The Board has approved the addition of the PPO Nebraska coverage option to the package of coverage currently available under the NMA plan. Information on the existing coverages and the additional PPO coverage will be distributed to association members in the near future. Association members not currently covered under the plan are encouraged to consider coverage. Information can be obtained from the Association office.

20. FINANCES

The 1994 Budget of the Association is $718,473. This reflected a 5.4% increase over the 1993 Budget. The Board spends a considerable amount of its time monitoring and analyzing the Association's financial status, relating both to the categories of income and to the expenditures necessary to operate our Association. The Board anticipates that the Association will have an estimated cash balance on December 31, 1994, of approximately $46,200. When projecting the income and expense figures for 1995, it becomes evident that there could well be a deficit of approximately $50,000 by December 31, 1995. The Board has few options in addressing this situation. The first option is to continue to closely monitor the expenditures of the Association to determine that all dollars are expended in the most efficient manner possible. The second option is to increase the number of dues paying members and the categories and use of non-dues income sources, which the Board continually strives to do. In this regard, we solicit the assistance of all Association members to encourage their non-member colleagues to join the federation of organized medicine. The Board encourages members to take part in the products and services endorsed by the Association, namely the Blue Cross/Blue Shield group health insurance plan, the Bartling & Hinkle collection service, the NMA Visa gold card as well as the other products and services that are available. The Association receives a fee for the utilization of the various products and services which assists in maintaining the membership dues rate at the lowest level possible.

The policy of the Association has been to only request a dues increase when it is absolutely necessary. The Association's dues were increased by $25 for the 1993 membership year, and they remained the same, at $360, for 1994.

The Board has considered this matter in great detail and presents the following information to the House of Delegates. As background, the House of Delegates is reminded that the Association has received 1% of the premium income of the NMA Blue Cross/Blue Shield insurance plan for many years. In September 1992, the Board authorized discussions with Blue Cross/Blue Shield to investigate the implementation of a settlement agreement which would permit the Association to be involved in decisions regarding how any excess premiums would be disbursed following the completion of a plan year, recognizing there would be income taxes due on the amount received from Nebraska Blue Cross/Blue Shield. Following further discussions regarding the settlement agreement and its complicated formula and computations, the Board approved the implementation of the settlement/participation agreement on January 28, 1993. Due to an exceptionally low number of major claims during the 1992 contract year (October 1, 1992, through September 30, 1993), the Association's plan accumulated a sizeable rate stabilization reserve which according to the formula remains on deposit with the company. The exceptionally favorable experience has continued during the current contract year which ends on September 30, 1994. As of June 30 of this year, the plan has accumulated a net settlement amount of approximately $439,000. This number can increase somewhat with favorable experience throughout the remaining portion of the contract year or it can be reduced substantially if a large number of major claims are received.

Pending the opinion from the Nebraska Medical Association legal counsel and accountants, the Board of Directors' recommendation regarding the legal disposition of the Blue Cross/Blue Shield settlement account funds and management of the projected 1994-1995 budget deficit is deferred. As soon as the necessary opinions are received, the Board of Directors will make the appropriate recommendations to the House of Delegates as regards management of the 1994-1995 budget. In the event the desired opinions are not received by the time of the 1994 Fall Session House of Delegates, the House must decide whether or not to delegate its authority to the Board of Directors to act in its behalf and in the best interests of the Nebraska Medical Association as regards the management of the budget including a possible dues increase. The alternative is to call a special session of the House of Delegates.

21. ADDITIONAL EMPLOYEE

The Board approved the addition of a seventh employee in the Association office. Subsequent to the addition of the sixth employee in 1977, the activity level of the Association has increased substantially. In 1977, the NMA had 1,518 members and there are now 1,878 members. The association's budget in 1977 was $203,488 and the 1994 budget is $718,473 which directly reflects the increased activities by the Association's commissions, committees and other organizational bodies. In 1977, the Annual Session report of the Policy Committee (the predecessor of the Board of Directors) contained 12 items. The Board's report to the 1994 session of the House contained 30 items with multiple issues under some of the items. Several years ago the Association consumed approximately 20 cases of white paper in the 12 month period, and between December 21, 1993, and April 28, 1994, the Association used 32 cases of this product. The Board is aware of the increased activity of the Association and the resulting workload, and agreed with the necessity of adding an additional staff person.

22. FEDERATION STUDY CONSORTIUM

The Association was invited to provide a nominee to serve on the AMA sponsored Federation Study Consortium which is to study the future of organized medicine and make appropriate recommendations. It is also the goal of the Consortium to develop unity of physicians, hospitals and health care organizations. As requested by the AMA, three NMA nominees were submitted for consideration. The AMA selected Dr. Allen Dvorak as a Nebraska Medical Association nominee to serve on the Federation Study Consortium.

23. COMMUNITY HEALTH SERVICES

The Board considered a request from the Nebraska Department of Health that the Association support the design and implementation of a system of community health services for the State of Nebraska. The Board informed Dr. Horton that the rural areas of the state need some type of public health direction to make efforts more cohesive and effective. It was also pointed out that some attention should be paid to the possibility of establishing common geographic boundaries for various health related programs such as the

system of community health services - State of Nebraska, Department of Social Services - Medicaid, and the Emergency Medical Service Regions. The Board determined that the Association should support the proposal and it was requested of Dr. Horton that there be strong physician input as the program is developed.

24. PEW FOUNDATION ACHIEVEMENT AWARD

The Association was requested to provide a letter of support to aid the University of Nebraska Medical Center in its effort to be awarded a Pew Foundation Achievement Award for the university's activities in the area of primary care expansion. The Board supported the application.

25. TECHNICAL ADVISORY COMMITTEE

A Nebraska insurance carrier requested the Association provide a list of physicians from which a medical policy advisory committee could be selected. Inasmuch as numerous insurance companies could request similar recommended lists, the Board determined that the Association will study the possibility of the establishment of a technical advisory committee which could be made available to any insuring entity under a fee arrangement. This matter will be considered further by the Board.

26. PRACTICE PARAMETERS

The Board received a recommendation that the Association be involved in the review and consideration of various practice parameters as they are proposed. It was suggested a specific committee be established for this purpose. The Chairman of the Board will proceed with the suggestion when it appears appropriate and advisable to do so.

27. CONTINUING MEDICAL EDUCATION

The Board decided that the Scientific Sessions Committee should be asked to serve as the organizational body which informs Association members of the various continuing education mechanisms and opportunities that are available. The Board is suggesting that the Scientific Sessions Committee provide socio-economic programs to county medical societies, possibly through a speaker's bureau, and the committee inform physicians of programs that are already available from various other entities. The Scientific Sessions Committee will be addressing this recommendation in the near future.

28. CONGRESSIONAL CONTACT

The Association has contacted our Congressional delegation on several occasions subsequent to the 1994 Annual Session. We joined with the AMA in a unified effort to contact the Congressional delegation in rebuttal to the insurance industry's attacks on the Health Care Improvement Act of 1993, particularly focusing on the anti-trust reform issues of importance to organized medicine. The Association joined with the AMA in a unity letter dealing with the Patient Protection Act, and we directed a specific letter to each member of Nebraska's Congressional delegation dealing with a request for direct support of the Patient Protection Act.

29. PREVENTIVE LAW SEMINAR

The Board of Directors considered and approved the scheduling of a jointly sponsored physician and staff preventive law seminar co-sponsored by the Association and Cline, Williams, Wright, Johnson and Oldfather Law Firm which serves as NMA counsel. The seminar will take place in conjunction with this Fall Session. Consideration will be given to scheduling similar seminars in the future.

30. HEALTH QUEST

The Board approved the participation of the Association in the Health Quest exhibit at the 1994 Nebraska State Fair. The Association's participation in this event has been developed by the Commission on Public Affairs, and financial assistance for this event was provided by the Nebraska Medical Foundation.

31. "EVERY WOMAN MATTERS" PROJECT

The Board reviewed a proposal to form a partnership between the Association and the Nebraska Department of Health to promote use of mammography for women over age 50 and for participation in the "Every Woman Matters" program. The Board approved participation in this activity which now functions under the auspices of the Commission on Public Affairs.

32. PHYSICIAN LICENSURE/DISCIPLINE

Subsequent to the 1994 Annual Session of the House of Delegates, the Board met with representatives of the Board of Examiners in Medicine and Surgery for purposes of discussing issues of mutual interest. The Board of Directors invited the Board of Examiners to provide the Association with proposals for remedial action if such should become available. The Association also monitored the meeting of the Disciplinary Action Committee for Health Professionals of the State Board of Health. It is anticipated that this committee will schedule subsequent meetings or sub-committee meetings for purposes of addressing specific issues regarding licensure and/or discipline of health professionals. The Association will continue to monitor and/or be involved in this committee's activities. In addition, the State of Nebraska has announced that a comprehensive review of Nebraska's Uniform Licensing Laws will take place. The Association was invited by Mark B. Horton, M.D., Director of the Nebraska Department of Health, to provide input on this issue and the Association subsequently forwarded a letter to Dr. Horton confirming the Association's desire to name Association physician representatives to serve as participants in the project.

33. BLUE CROSS/BLUE SHIELD CLINICAL LAB POLICY

The Board considered a proposed policy regarding laboratory service reimbursement that was distributed to Nebraska physicians by Nebraska Blue Cross/Blue Shield. It was the Board's decision that this matter should be considered by the NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems. The Ad-Hoc Committee will report to the House of Delegates on its activities regarding this issue.

34. RURAL HEALTH CONFERENCE

The Board reviewed a request from the Nebraska Office of Rural Health regarding a $250 contribution to aid in supporting the Rural Health Conference scheduled in early September and determined that the Association would support the event.

35. STRATEGIES FOR HEALTH CARE REFORM PROJECT

The Board reviewed the application to the Robert Wood Johnson Foundation for the Nebraska Department of Health's "Strategy for Health Care Reform in Nebraska" project and responded with a letter which expressed the Association's support for such a planning process and grant application but indicating that it's the Association's opinion that a health purchasing cooperative must be voluntary, that traditional fee for service plans providing for patient choice have no alternative in many areas, and that managed care programs should embody the "willing provider" concept. The Association expressed support for practice guidelines development to reduce defensive medicine and avoid malpractice suits, and indicated that this can best be approached by using the "deemed status" approach encompassing the standards and guidelines of existing entities. The communication also indicated that as regards certificate of need, the Association continues to believe that the market place is a better regulator than CON statutes, and indicated that the inclusion of the Governor's Blue Ribbon Coalition in the proposed work group was vital.

36. DOCTOR CORNELIUS SELECTED AS ALTERNATE DELEGATE

The State Medical Society of Wisconsin requested that Carl J. Cornelius, Jr., M.D., attend the 1994 June Meeting of the AMA House of Delegates as their guest to assist with the election of a Wisconsin nominee for the AMA Board of Trustees. The NMA Board of Directors determined that Doctor Cornelius should be allowed to fill an NMA Alternate Delegate position for this one meeting in an effort to assist the Medical Society of Wisconsin. We are pleased to report that the individual, Dr. Tim Flaherty, was elected to the AMA Board of Trustees.

37. LES VESKRNA, M.D., SELECTED

The Board of Directors approved the naming of Les Veskrna, M.D., to serve as an Alternate Delegate to the June 1994 AMA Young Physicians Section Meeting in Dr. Michelle Petersen's absence.

38. AMA STRATEGIES FOR CHANGE WORKSHOP

The American Medical Association offers a strategy for change workshop which is focused at assisting physicians in understanding the implications of managed care. The workshop presents national perspectives, local interpretations, and various self-assessment exercises and interactive techniques. Nebraska Blue Cross/Blue Shield has offered to co-sponsor the program and the NMA has invited the Nebraska Academy of Family Physicians to also join in sponsoring the workshop. Association members will be informed of the date for the event and provided background information on participation.

39. TELECOMMUNICATIONS AND INFORMATION PLANNING GRANT

The Association provided a letter of support for the State of Nebraska's Telecommunications and Information Infrastructure Planning Grant Project. The Association supported the University of Nebraska Medical Center specifically in its efforts to determine the state's current and future needs for information technology and infrastructure as it relates to health care.

40. NOMINATIONS AND APPOINTMENTS

The Board is routinely asked to provide nominees for recommended appointment to various state boards and committees and to various groups outside state government. The following were recommended for appointment during the past several months.

- HOSPITAL ASSOCIATION DATA PROGRAM

  The Association was requested to provide representatives to serve on the Nebraska Association of Hospitals and Health Systems' Hospital Information System Technical Advisory Group. The representatives selected by the Board to serve on various work groups were: Robert G. Osborne, M.D., Darroll J. Loschen, M.D., and David R. Little, M.D.

- DMV ADVISORY BOARD

  The Association was requested to provide nominees for appointment to the Health Advisory Board which functions under the auspices of the Nebraska Department of Motor Vehicles. Nominated to serve were: Howard Dinsdale, M.D., Lyal G. Leibrock, M.D., Thomas C. Bush, M.D., Robert G. Osborne, M.D., and Les Veskrna, M.D.

- EMERGENCY MEDICAL CARE BOARD NOMINEE

  The Association was invited to provide a nominee for the Board of Advanced Emergency Medical Care. The name of Robert D. Harry, M.D., of Lexington was provided to the Department by the Association.

- BOARD OF EXAMINERS IN MEDICINE & SURGERY

  The Association was invited to provide nominees for possible appointment to two positions on the Board of Examiners. To complete the term of Larry D. Toalson, M.D., who resigned from the Board, the Association has nominated John L. Reed, M.D. To replace Robert D. Harry, M.D., who did not wish to be reappointed for a second term, the Board has requested the Greater Nebraska Caucus provide it with the name of a nominee.

The Board of Directors presents this report to the House of Delegates for adoption, and stands ready to consider items which may be referred to the Board during this Fall Session.

REPORT OF THE DELEGATE TO THE AMA

INTRODUCTION

The AMA House of Delegates met in Chicago, June 12-16, 1994, with 430 delegates in attendance of which 338 represented state medical associations, 82 national medical specialty societies, and 10 delegates representing resident physicians, medical students, medical schools, hospital medical staff, young physicians, Military Service, United States Public Health Service and Veteran's Administration. The House considered 212 resolutions and 106 reports which dealt with a wide variety of national issues of critical importance to the future practice of medicine and the future health and well-being of the American people.

HEALTH SYSTEM REFORM

As the nation's lawmakers continue to direct atten-

tion to reforming the health care system, the various aspects of the proposals under consideration easily dominated the discussions at the Annual Meeting. In what was one of the longer open hearings in our AMA's history, scores of speakers presented testimony to help guide the AMA's leadership in the coming months of legislative wrangling. The debate continued on the floor of the House as the delegates considered Board and Council reports and a large number of resolutions.

When everyone had been heard, the delegates voted to adopt the following policy statements:

1. That the Board of Trustees continue to implement AMA policy to achieve universal access and coverage through an approach that may utilize employer and/or individual responsibilities for payment while permitting the individual to choose and own his or her health insurance plan, and continue to encourage health IRA's and a phase-in mechanism, exploring all concepts that accomplish coverage for and access to health services for all Americans recognizing the needs of individual states, and report back to the House on its efforts at the 1994 Interim Meeting.
2. That the AMA may support a health system reform bill that does not include every component of the current AMA Health System Reform policy.
3. That the AMA continue to strongly support a pluralistic approach to achieving universal access to health services.
4. That the AMA strongly emphasize and encourage the development and use of health savings accounts as outlined in an informational report of the AMA's Council on Medical Service as an integral component of its advocacy efforts toward achieving universal coverage.
5. That the AMA declare its strong support for those elements of health system reform proposals that are consistent with AMA policy.
6. That the AMA study ways to discourage the present control of employee health insurance choices by employers and report back to the House of Delegates at the 1994 Interim Meeting.

REQUIRING PHYSICIAN PARTICIPATION IN HMO'S IN ORDER TO JOIN A PPO PANEL

The House considered a report of the Council on Medical Service that pointed out that AMA policies now call for choice among fee-for-service, prepaid, and point of service options. The report states that the AMA has advocated these policies vigorously and effectively with the White House and the Congress.

The House adopted the following policy statements:

1. That the AMA reaffirm policy which calls for each employer or "health alliance" to offer two or more affordable fee-for-service plans offered on an annual basis, where available.
2. That the AMA reaffirm policy which calls for all health plans that restrict a patient's choice of physician or hospital to offer a "point-of-service" feature in which patients may see physicians out of the plan.
3. That the AMA adopt as policy that any point-of-service options under health system reform have out-of-plan cost-sharing levels that are nonpunitive, actuarially determined and affordable.

BENEFITS OF BALANCE BILLING

Testimony was presented to the Reference Committee that physicians' continued ability to set their own fees was in severe peril as a result of various legislative and policy initiatives, as well as the growth of managed care plans. The members of the committee agreed and pointed out that the AMA has sufficient policy on the right to contract, which must continue to receive high priority.

The House adopted the following statements:

1. That the AMA reaffirm policies calling for the preservation and expansion of the physician's right to establish fair fees.
2. That the AMA reaffirm policies calling for patients to be free to contract with the physician of their choice to obtain medical services regardless of insurance payment.

SUPPORT FOR CORE PUBLIC HEALTH FUNCTIONS

The House received three resolutions expressing concern for continued support of programs in disease prevention and health promotion in health system reform. The House adopted the following statement:

That the AMA support establishment of a stable source of funding dedicated to core public health functions in the context of health system reform.

DEFINITION OF PRIMARY CARE

After nearly a year of working on the subject, the Board of Trustees submitted a report that resulted from the creation of a "Task Force on Primary Care." At the last Interim Meeting, the Speakers organized a special open hearing on the definition of primary care so that all viewpoints could be expressed for the information of the Task Force. The Reference Committee again heard extensive testimony on this important subject and recommended some amendments to the Board's policy statements which were accepted by the House as follows:

1. That AMA policy state that primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, curative, counseling, and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a physician over time. Care may be provided to an age-specific or gender specific group of patients, as long as the care of the individual patient meets the above criteria.

2. That the AMA encourage the efforts to define what constitutes primary care services. Data should be collected on which specialities currently provide these services, and how these services are integrated into the practice of physicians. Such data are essential to determine future physician workforce needs in primary care.

3. That the AMA encourage that training programs for physicians who will practice primary care include appropriate educational experiences to introduce physicians to the required knowledge and skills, as well as to the types of services and

the modes of practice that characterize primary care.

4. Where case management or coordination limit access to appropriate medical care patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount.

PHYSICIAN WORKFORCE PLANNING STRATEGIES

The House received a report prepared by two councils and seven resolutions on the subject of workforce planning. The Reference Committee reported that it heard extensive supportive testimony and recommended the following policy statements which were adopted as amended:

1. Physician workforce planning should be based on physician-to-population ratios, taking into account regional and national demographic characteristics and needs, and any alterations in the structure of the present healthcare delivery system. Such planning should not be based on an arbitrary percent distribution by specialty.
2. Any analysis of physician supply should be based on numbers of physicians and the proportion of time that they are actively involved in patient care and on the different health delivery system where they practice rather than on the total physician population.
3. Attempts to adjust the physician workforce should consist of an appropriate mix of market and other forces; utilizing voluntary, private sector planning; the initiation of appropriate incentives; and addressing the wide range of factors which influence personal career choice.
4. Planning to restructure the physician workforce should consider the utility of the following strategies, singly and in combination: limiting the number of medical students, limiting the number of entry level residency positions, and retraining of practicing physicians.
5. In order to maximize physician involvement in workforce planning and to respond to current pending legislation designed to place planning solely in federal hands, the planning process should both redefine existing structures and consider additional bodies for a private initiative in workforce planning. Medical students and residents should be involved in all levels of workforce planning. The physician workforce planning infrastructure could include three basic components:
   a. creation of a "National Health Workforce Advisory Council"
   b. establishment of a "Graduate Medical Education Commission"
   c. establishment of a graduate medical education consortia to provide a mechanism for the integration of undergraduate and graduate medical education activities on a local, regional, or state basis.

MEMORIES OF CHILDHOOD ABUSE

The Council on Scientific Affairs submitted a thoughtful report on memory enhancement methods used on cases of possible childhood sexual abuse. The report refined current AMA policy and received widespread media attention. The Council stated that the AMA has a long history of concern about the extent and effects of child abuse.

The House of Delegates adopted as amended the following policy statements:

1. That the AMA recognize that few cases in which adults make accusations of childhood sexual abuse on recovering memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases.
2. That the AMA encourage physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims.
3. The AMA considers recovered memories of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication.
4. That the AMA encourage physicians treating possible adult victims of childhood abuse to subscribe to the Principles of Medical Ethics when treating their patients and that psychiatrists pay particular attention to the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.
5. That the policy which deals with the refreshing of recollections by hypnosis be reaffirmed.

VIOLENCE IN AMERICA

The House adopted a number of policies related to the epidemic of violence in America:

1. That the AMA working with the AMA Alliance, continue its leadership role in bringing physicians and other professionals and their organizations into collaborative efforts to prevent and reduce family violence in our society and continue to make family violence a centerpiece public health issue for the federation and devote the necessary resources to support a continuing campaign to reduce family violence. The Board was asked to review the recommendations from the work groups from the ABA-AMA National Conference on Domestic Violence held in March 1994.
2. That the AMA support the efforts of the International Association for Healthcare Security and Safety, the AHA, and the JCAHO to develop guidelines or standards regarding hospital security issues and recognize these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised.
3. That the AMA encourage physicians to work with their hospital safety committees to address the security issues within particular hospitals and also encourages physicians to become aware of and be familiar with their own institution's policies and procedures.
4. That the AMA urge that hospital safety committees include physicians and that emergency departments be recognized as high risk environments for violence and submit a report on guns in hospitals at 1-94.

5. That the AMA urge the entertainment industry to make fundamental changes in the rating system, which will give consumers more precise information about violent and sexual content of motion pictures, television and cable television programs, and other forms of video and audio entertainment, thereby enabling consumers to make more meaningful decisions for themselves and their children about what they view or hear.
6. That the AMA urge consideration be given to the potential development of a Television Violence Code with input from the government, the television industry, and the public, including the medical profession, to address issues relating to all television violence, including news reports and entertainment.
7. That the AMA work with the entertainment industry and other groups interested in reducing violent content of media programming, to incorporate age classifications into the ratings system that reflect scientifically demonstrated developmental periods during childhood and adolescence such as 3- to 7-year-olds, 8- to 12-year-olds, and 13- to 17-year olds.
8. That the AMA urge the entertainment industry to develop a uniform ratings system that is easy for consumers to understand and which can be applied across existing and future entertainment technologies.
9. That the AMA urge physicians to counsel parents about the known effects of media violence on children's behavior and encourage them to reduce the amount of violent programming viewed by their children.

MANAGED CARE FAIRNESS

The Hospital Medical Staff Section and the delegations from Ohio and Texas introduced resolutions addressing the many problems associated with physicians practicing in managed care plans. The Reference Committee reported that these resolutions received strong support from those who testified.

The House adopted the following policy statement:

A. That the AMA continue to advocate for the enactment of state and federal laws and regulations that would provide for patient protections and physician fairness, including:
   1. permitting physicians to negotiate individually and collectively with managed care organizations on the terms and conditions of physician participation in a managed care organization's health benefit plans.
   2. providing for formal input by practicing physicians in the development and refinement of the medical policies of a managed care organization, especially those policies related to physician credentialing, performance review, and utilization management.
   3. requiring managed care organizations to disclose all participation requirements and selective contracting criteria to applying physicians.
   4. requiring managed care organizations to provide due process to physicians in all adverse selective contracting decisions.

B. That the AMA continue to encourage all state medical associations and national medical specialty societies to advocate vigorous support of the "Patient Protection Act" (HR 4527).

RESOLUTIONS

The Nebraska Medical Association House of Delegates instructed that two resolutions be forwarded to the AMA House for consideration during its June 12-16 session.

The first resolution addressed health system reform and proposed that the AMA express strong support for the Medical Service Account Concept with reimbursable tax credits and that the AMA convey this support to the members of the United States Senate and the House of Representatives. The House of Delegates adopted a recommendation that the Board of Trustees continue to implement AMA policy to achieve universal access and coverage through an approach that may utilize employer and/or individual responsibilities, for payment, while permitting the individual to choose and own his or her health insurance plan, and continue to encourage health IRAs and a phase-in mechanism, exploring all concepts that accomplish coverage for and access to health services for all Americans recognizing the needs of individual states, and report back to the House on its efforts at the 1994 Interim Meeting.

The second resolution proposed that the AMA study reimbursement of rural primary care services in general and also study the reimbursement for primary care services under the Resource Based Relative Value Scale. The House of Delegates adopted this resolution.

CONCLUSION

The annual meeting represented Dr. Jerry R. Schenken's last meeting as an official member of the Nebraska Delegation. It has become a tradition at the annual and semiannual meeting of the American Medical Association House of Delegates for the Nebraska Delegation to meet for dinner one evening for both camaraderie and to discuss evolving issues at the AMA House of Delegates Meeting. At our last dinner on June 13, 1994, in Chicago, special recognition was given to Dr. Schenken for his dedicated service to the NMA and AMA. Dr. Schenken has completed a noteworthy tenure of service to the AMA serving as a member of the Board of Trustees from 1985-1994. In his position as an AMA Trustee, Dr. Schenken became intensely involved in the activities of the Board of Trustees through membership on the Finance Committee, 1985-1994; Executive Committee 1986-1991; Committee on Organization and Operation of the Board, 1989-1991, and this Committee's Chairman, 1993-1994; Secretary-Treasurer of the Association, 1990-1991; and Nominating Committee, 1991-1994. Throughout all of these activities, Dr. Schenken never lost contact with his constituency in Nebraska as reflected by his Presidency of the Metropolitan Omaha Medical Society in 1987 and his continued involvement in the House of Delegates of the NMA. Now that Dr. Schenken has completed his tenure of office with the AMA, he is returning to intensified activity in his professional career as a pathologist and continued participation in the activities of both the MOMS and NMA. The NMA delegation greatly appreciates and recognizes the efforts of Dr. Schenken within the AMA.

During the Annual Meeting, Carol A. Aschenbrener was reelected to an additional term on the AMA Council on Medical Education. A member of the Nebraska Delegation, Dr. Allen D. Dvorak, served as a member on Reference Committee E which deals with issues related to Science and Technology.

RECOMMENDATION

The members of the NMA-AMA Delegation recommend to the House the following resolve: "In sincere appreciation and recognition of his service to the citizens of Nebraska and the medical profession, the NMA at its 1994 semiannual meeting applaud and sincerely thank Dr. Jerry R. Schenken of Omaha, Nebraska, for his long outstanding service as an AMA Trustee.

Respectfully submitted,
Allen D. Dvorak, M.D.

REPORT OF THE DELEGATE TO AMA YOUNG PHYSICIANS SECTION

The Young Physicians Section of the AMA met June 10-11, 1994, at the Chicago Hilton & Towers in Chicago, Illinois. Twenty-three resolutions were debated with eleven being adopted and several referred for further study.

Of interest to Nebraska young physicians is a resolution the YPS adopted supporting efforts to increase reimbursement of primary care services in underserved areas, both rural and urban. This was introduced as Resolution 121 before the AMA-HOD and was adopted.

A second issue pertaining to a large number of Nebraska young physicians is Resolution 15 which directs the AMA-YPS to support modification in HCFA policies to allow reimbursement to primary care physicians for the provision of appropriate concurrent care for hospitalized patients also cared for by referral specialists and that the AMA-YPS seek to have policies for concurrent care reimbursement provide reimbursement to all physicians for actual time spent in care of patients, counseling patients and their families, organizing family meetings, and otherwise acting on the patient's behalf as case manager. This resolution directs the AMA-YPS Governing Council to issue a report to the Assembly at I-94 detailing specific actions the AMA has taken in support of its existing policy on concurrent care.

Resolution 5 was adopted calling for the AMA-YPS to support efforts to classify cigarettes as nicotine dispensing devices and to support efforts to place the regulation of tobacco under the jurisdiction of the FDA.

The most controversial topic in this session was a resolution calling on the AMA-YPS to support the existing Council on Ethical and Judicial Affairs (CEJA) opinion on organ procurement from anencephalic infants. It mandated the YPS delegate to the AMA-HOD to extract from the consent calendar CEJA opinion 10-A-94, "Anencephalic Infants as Organ Donors," which reverses current CEJA opinion. The debate surrounding this resolution was very intense and emotional. Resolution supporters felt the revised CEJA opinion may create a third category of existence between life and death. Those opposed to this resolution and in favor of the revised CEJA opinion felt (1) organ donation in the case of an anencephalic infant benefits others, and (2) gives solace, purpose and choice to parents. The decision was made to refer this issue to the AMA-HOD for debate. The AMA-HOD took up this issue as CEJA Report 10 where it was extracted, debated, and filed. An additional report explaining CEJA's reasoning is due at 1-94.

This meeting of the YPS was, again, a positive learning experience. I found my belief that physicians are the best advocates for our patients strengthened. I wish to thank the NMA and the NMA-YPS for allowing me to serve as Delegate.

Respectfully submitted,
Tamara R. Johnson, M.D.

REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

Dear Colleagues:

The liver transplant team, lead by Drs. Byers Shaw, M.D., of the Department of Surgery, and Michael Sorrell, of the Department of Internal Medicine, completed its 1,000th liver transplant on August 16, 1994. In addition to local and regional referrals, patients have been referred to UNMC from all over the world for liver transplantation. In recognition of UNMC's growing program and commitment to excellence in solid organ, bone marrow and cellular transplantation, we are moving forward to build a national center for transplantation at UNMC. This new center will link transplant research and education to transplantation-related care in a new facility that will be built on the present site of Conkling Hall. The center will introduce an innovative delivery system - cooperative care - that focuses on the needs of the patients while reducing health care costs. After the postoperative recovery period, patients may be moved to the new facility which will include medical apartments and a day hospital. Each patient will have a care partner (a family member or friend) who participates actively in the patient's care. Two floors of research space will foster interaction between the clinician and the scientist to speed translation of bench research to the bedside. Construction on the center, which will serve as a national model to test health care delivery strategies for the 21st century, is expected to begin in 1996. The estimated cost of the proposed 180,000 square-foot facility is $42 million, to be supported by both public and private funds.

In my last report to the NMA, I mentioned the LCME survey of the College of Medicine for accreditation. In June I received the LCME survey report. I am pleased to report that the COM received continued full accreditation of the educational program leading to the M.D. degree. The LCME was impressed with the rapid accomplishments of the institution since the last survey, and plans for the future.

The NU Board of Regents approved the formation of a Department of Radiation Oncology effective July 1, 1994. Dr. Glenn V. Dalrymple has been appointed interim chair. After the department is organized, a search committee will be formed to recruit a depart-

ment chair. The department will have an education, service and research mission which will enhance Eppley's position for designation as a clinical or comprehensive cancer center by the NCI.

I am pleased to announce the appointment of Dr. Bruce Buehler as Chair of the Department of Pediatrics, pending approval of the Board of Regents. This is an outstanding appointment and a well deserved recognition of the fine work Bruce has done. This successful recruitment is a very important step in our efforts to build a distinguished Department of Pediatrics.

Finally, please join me in congratulating Dr. Layton (Bing) Rikkers, Professor and Chair of the Department of Surgery, on his appointment as Chairman of the American Board of Surgery.

My best wishes for a successful Fall meeting.

Respectfully submitted,
Harold M. Maurer, M.D.
Dean
College of Medicine
University of Nebraska
Medical Center

REPORT OF THE BOARD OF EXAMINERS IN MEDICINE & SURGERY

This fall continues the dizzying changes in the practice of medicine. Since Spring, there has been much discussion and much heat but little light about medical licensure and disciplinary problems. However, there are two recent publications I would recommend to you. One is the report by Mr. Pallesen in the NMA about the function of the Medical Board, and the report by Mr. Doug Curry in the Nebraska Health Law Digest. These are very appropriate and address this problem very realistically. I would urge all members of the Association to read both of these articles and to remember them. Also, since we are all in the process of renewing our licenses, you will have received a form from the Department of Health regarding the new changes required by LB 1223. These are the self reporting laws and although the regulations are not yet finalized, this will bring about a radical change not necessarily for the better.

The discussion that has been going on in Washington about "health care reform" has almost nothing to do with the care of a patient. I urge the membership to do two things. First, review your Hippocratic Oath, try to understand it and live by it. If one follows that oath, one will most likely never have problems with the disciplinary system. We as physicians must regain a seat at the table discussing health care reform. The second thing I urge the membership to do is to become more involved in this discussion on the changes of health care reform. The reason for this is elegantly simple. No one knows more about health care delivery than you and I. We are involved in the doctor-patient relationship daily and even hourly. We know the problems that occur when insurance carriers step between a doctor and a patient. We know the problems that occur when the state does the same thing. We are the only true "patient advocates". We must be involved not only with policing ourselves but in protecting the patient.

You will notice that the two articles I urge you to read are written by attorneys. The system is basically written and run by attorneys. There is very little input by medical practitioners. Mr. Curry states this quite clearly in his discussion and Mr. Pallesen also describes it. This happened because we, as physicians, have allowed it to, and we must step up to the plate and care for our patients. This also involves fighting some battles that are not only in the hospital but still none the less need to be fought. I urge you to become involved so all of us do the right thing for our patients.

Thank you.

Respectfully submitted,
Philip S. Metz, M.D.
Chairman

REPORT OF THE STATE DEPARTMENT OF HEALTH

Thank you for this opportunity to report to you on the Nebraska Department of Health's current activities.

THE CHALLENGE OF PUBLIC HEALTH

Clearly, the mission of public health — assuring the conditions necessary for the health of every individual in the state — can not be accomplished without the assistance of the medical community.

The Nebraska Department of Health, and public health, need the support of the Nebraska Medical Association in accomplishing what I consider to be the three most important public health initiatives for the state.

First, the formal recognition of and support for the core public health functions as a part of health care reform. Second, the development of a formal network of pubic health services in the state through a system of regional planning set out in the Community Health Service plan developed by the Nebraska Department of Health. Third, accomplishment of three specific Healthy People 2000 objectives: 1) raising the immunization rates for 2-year-olds in the state from 60 percent to 90 percent by the year 2000; 2) increasing the number of women over 50 years of age who are being adequately screened for breast cancer from 25 percent to 60 percent by the year 2000; and, 3) decreasing the use of tobacco products in the state from 20 percent to 15 percent and decreasing the number of youth who pick this habit up during the teen years from 34 percent to 15 percent.

I would like to invite the Nebraska Medical Association to study and to formally adopt a statement articulating the core functions of public health in Nebraska and resolving that these core functions be supported in whatever health care reform program is adopted for our state. I invite the Association to study the recently released Community Health Services Plan, communicate to the Nebraska Department of Health suggested modifications and revisions, and work with the Department to accomplish its intent, which is to ensure the availability of core public health services to all citizens of our state.

Finally, I invite the state's medical care providers to ensure that clinical preventive services addressing

childhood immunization, early detection of breast and cervical cancer, and the reduction of tobacco use are consistently used in every physician's office. By ensuring that the core functions of public health are explicitly recognized in health care reform, by working to ensure that all citizens have access to core pubic health services, and by working together to ensure the accomplishment of three specific Healthy People 2000 objectives, we will truly be working in partnership for the betterment of all Nebraskans. I look forward to working with you to meet these challenges in the months and years ahead.

THE CORE FUNCTIONS OF PUBLIC HEALTH

- promoting healthy lifestyles and appropriate use of health services;
  example: The goal of the Tobacco Free Nebraska Program is to reduce the use of tobacco by youths and adults.

- protecting the public from unhealthy and unsafe environments;
  example: The mission of the Safe Drinking Water Program is to monitor and assure the quality of water offered by public water systems.

- preventing disease, disability, and premature death;
  example: The goal of the Injury Prevention Program is to reduce intentional and unintentional injuries among Nebraskans.

- providing or ensuring access to needed health services:
  example: The purpose of the Family Reproductive Health Program is to assure that family planning and other services are available to women of child-bearing age.

- investigating and controlling outbreaks of illness;
  example: When individuals in Omaha and Lincoln became sick with a strain of bacteria called E. coli, the state epidemiologist was able to find the approximate source of the affected hamburger and to take action to ensure that more people were not infected.

- protecting the environment, including the safety of air, water, and workplaces;
  example: A town whose water system was found to be high in nitrates is offered to supply bottled water to pregnant women and infants.

- collecting and analyzing data to rapidly identify and detect emerging health problems;
  example: Death certificates filed at the Bureau of Vital Statistics are analyzed to determine the top causes of death among Nebraskans • heart disease, cancer, cerebrovascular disease, pneumonia, accidents, chronic lung disease, diabetes mellitus, atherosclerosis, suicide and kidney disease.

- educating and informing the public to reduce health risks and increase personal responsibility;
  example: Greater awareness of tobacco use as a risk factor for heart disease and cancer has resulted in a decrease of the number of adults who smoke. Only 20% of adult Nebraskans now smoke, compared to 24 percent seven years ago.

- maintaining the accountability of public institutions;
  example: Department of Health staff routinely check mammography equipment to assure its safe and effective operation.

- providing public health leadership and policy development;

  example: Public health systems provide early warning that jurisdictions must address emerging health problems, such as Lyme disease or rabies, and provide scientific guidance for policy decisions.

- maintaining public health laboratories;

  example: State public health laboratories guarantee accurate, reliable test results. These results are used to investigate and control public health hazards such as high blood lead levels. State labs identify rare genetic and metabolic diseases through screening of all newborns.

- training and education of public health professionals.
  example: Unique skills such as epidemiology and biostatistics must be cultivated in the public health field to guarantee that society will be able to identify statistically important health changes, and to discover the cause of the changes.

LEGISLATION

1994 has been a good legislative year for health. We are extremely pleased with the Governor's heath care reform initiatives. LB 1223 contained the universal childhood immunization program, increased funding for the health professional student loan program which encourages rural practice, funds to develop a statewide data system, and changes addressing licensed professional discipline.

LB 1222 included important health insurance reform measures, including the use of a single billing form and definition of pre-existing medical conditions. LB 817 included important anti-trust measures.

Other bills with very significant public health implications are LB 900, which allows nonpharmacists to dispense certain pharmaceuticals in public health clinics, and LB 819, which mandates HIV status reporting.

VACCINES FOR CHILDREN PROGRAM

The implementation of the federal Vaccines for Children Program (VFC) created by the Omnibus Budget Reconciliation Act of 1993 is scheduled for October 1, 1994. The program's goal is to raise childhood immunization levels in the United States among infants and young children. The program will supply — at no cost to public health care providers and private health care providers who agree to participate — federally purchased vaccine to be administered to certain eligible children. Approximately 60 percent of U.S. children are expected to benefit from the program.

Children through age 18 who are eligible to receive vaccine funded under this program are: 1) children enrolled in Medicaid; 2) children who do not have health insurance; and 3) children who are American Indian or Alaskan Native. In addition, children who have health insurance that does not cover vaccine can receive VFC-provided vaccines at federally qualified health centers and rural health clinics.

To participate in the program, providers need to agree to: 1) screen the parent or guardian to determine the child's eligibility (verification is not required); 2) maintain a record of this screening with the eligible child's record; 3) follow the recommended immunization schedule as established by the Advisory Committee on Immunization Practices and state law; 4) not charge for the vaccine — an administration fee, to be established by the Health Care Financing Administration, can be charged so long as immunization is not denied because the parents cannot pay the fee; and 5) provide vaccine information materials as prescribed by law.

A private health care provider is not required to accept a child into his or her practice or clinic merely because the child is eligible for immunization through the VFC program. A physician may participate in the VFC program without being a Medicaid provider.

To enroll, the provider agrees to participate in the program and signs a one-page provider enrollment agreement which is kept on file at the Nebraska Department of Health.

Private health care providers will also fill out a simple one-page "Provider Profile," which will be retained by the Department of Health to determine the number of patients expected to be seen for immunization services and the percentage of patients in the provider's practice that may be eligible for immunization through the VFC program. The information will be used to estimate necessary vaccine supplies.

The vaccines and combination vaccines offered by the VFC program are those providing protection against these nine diseases:

- diphtheria
- Haemophilus influenzae type B
- hepatitis B
- measles
- mumps
- pertussis
- poliomyelitis
- rubella
- tetanus

The VFC program will provide a ready inventory of federally purchased vaccine to the private provider and will eliminate some up-front costs in providing vaccine to eligible children. The system that health care providers use to purchase vaccine for their private-pay patients will remain unchanged.

The national goal to adequately vaccinate 90 percent of 2-year-old children depends on the support of private health care providers. The Vaccines for Children program contributes to this goal by removing vaccine cost as a barrier to immunizing eligible children in the care of private health care providers.

The Department of Health will mail out informational packets with forms to sign up for the program. For more information contact the Division of Disease Control, (402) 471-2937.

Nebraska was one of the states that had chosen to have a national warehouse distribute vaccine. Because this distribution system has been dropped as an option, negotiations on the federal level for alternate shipping methods in the private sector are continuing. While the VFC program is still expected to be initiated on October 1, there may be a postponement of shipments to private providers until arrangements can be made.

EARLY DETECTION OF BREAST AND CERVICAL CANCER PROGRAM

The most recent data from the Nebraska Behavioral Risk Factor Survey indicate that the percentage of women 50 and older who said they have had a mammogram in the last year increased from 34 percent in 1992 to 43 percent in 1993. This is the largest increase in the last five years.

This is very good news as the Department's Early Detection of Breast and Cervical Cancer Program, called "Every Women Matters," continues in its second year of operation. The program works with participating providers to make available free or low-cost office visits, Pap smears, pelvic exams, mammograms, and other related tests for income-eligible women who have no other source payment. The program includes follow-up, public and professional education, surveillance, evaluation, and quality assurance components. Over 250 providers currently participate in the program. A grant from the federal Centers for Disease Control and Prevention enables the Department to reimburse providers for screening exams for women without insurance or who have high deductibles on their insurance policies; low- and middle-income women who meet income eligibility requirements; minority women; and women age 50 and over who do not receive regular screening services.

As of August 1994, 5,000 women had enrolled in the program since screening began in late 1992. Six women with breast cancer and five women with cervical cancer have been identified. Treatment has been initiated for all of them.

It is a goal of the Every Woman Matters Program in the coming year to increase the percentage of women age 50 and over who have ever had a mammogram to 75 percent.

The Nebraska Medical Association has been a supportive partner of the Early Breast and Cervical Cancer Screening Program. A cooperative campaign to promote awareness among providers about the need to recommend mammograms to their patients and to encourage women to ask their providers about mammograms is under development.

October has been designated as Breast Cancer Awareness Month. The Susan G. Komen Breast Cancer Foundation and Junior League of Omaha will sponsor a fundraising event, The Race for the Cure, which is 5-K/1-mile Run/Walk beginning at Cancer Survivors Park in Omaha on October 2. The proceeds will fund definitive diagnosis exams for the clients of Every Woman Matters and benefit local and national breast cancer research.

HIV REPORTING

LB 819 mandates HIV reporting by name. Written informed consent is required prior to any person being tested. Details of the information to be included in the consent form is specified in the law. Health care providers are required to inform patients that if they wish to be tested anonymously, they will be referred to a state-funded counseling and testing site. The law also gives the Department of Health the

opportunity to offer related services, such as post-test counseling, partner notification, and early intervention services.

The law lists four exceptions to the requirement for written informed consent:

- when testing any human body part for purposes specified under the Uniform Anatomical Gift Act
- when a person is tested for insurance underwriting purposes

  (Written authorization is still required and written information about HIV is to be given that includes identification and reduction of risks.)
- when a person is committed to the Department of Corrections

  (The individual is informed when the test is performed, and education is provided about HIV that includes identification and reduction of risks. The results of the test and the meaning of the result will be given to the individual.)
- a person convicted of sexual assault, and in situations where emergency service personnel or health care providers experience a significant exposure (These situations are covered in other existing state statutes).

HIV reporting will be added to the list of conditions reportable within 7 days of detection in the revised rules and regulations regarding communicable diseases. A public hearing will be held in late 1994 to receive input regarding this addition.

HIV reporting from physicians and hospitals will follow current AIDS reporting methods, using the CDC HIV/AIDS case report forms. Health providers will send the reports to the Nebraska Department of Health in envelopes marked "CONFIDENTIAL-TO BE OPENED BY ADDRESSEE ONLY." Laboratories will use the lab reporting form currently in use. However, the larger labs will be asked to report HIV separately and mail the forms in an envelope marked as required. A "how to" packet will be compiled and distributed to all physicians, hospitals and laboratories prior to implementation of the HIV reporting law. For more information regarding HIV reporting, contact the HIV/AIDS Surveillance Program at (402) 471-0360.

The Nebraska Department of Health offers partner notification services on a voluntary basis to persons who test positive for HIV. If someone finds it difficult to notify their past and present sex or needle-sharing partners, the Department can assist with the notification process. When notification of a partner is performed by the Department, it is done in a very confidential manner and in person. The name of the HIV-positive person is never revealed to the partner under any circumstances. For more information on partner notification, contact the Division of Disease Control at the Nebraska Department of Health at (402) 471-2937, or your local county health department.

TEEN PREGNANCY

LB 1224, also known as the Welfare Reform Act, was passed during the last legislative session. It established the Governor's Roundtable to address welfare reform issues, including job creation, job training, tax incentives, unemployment compensation, and education programs. In addition, the bill required the Department of Health to study and make recommendations regarding teenage pregnancy prevention at a community level. The result is a report which examines trends in teenage pregnancy and childbearing, costs, predictors, a review of the policies and programs of other states, and an examination of what Nebraska is currently doing. Possible solutions include targeted health education, increasing access to information and health-related services, improved coordination of services, presenting alternatives, and changing attitudes and norms. It suggests that funding for programs could be provided to communities interested in addressing barriers to teen pregnancy prevention. Public input on the preliminary report is being sought, including input from teen parents and professionals serving teen parents. The report will be presented to the Governor's Roundtable by Sept. 15. Copies are available from the Bureau of Family Health Services in the Department of Health.

HEALTH PROFESSIONAL REPORTING REGULATIONS

A hearing was held at the end of August on regulations requiring health professionals and others to report negligence, incompetence and other violations of state licensing law to the Nebraska Department of Health.

The regulations will implement legislation passed during the last legislative session following a study of issues related to the regulation and oversight of professionals licensed by the Department of Health.

The regulations pertain to reporting by licensed health professionals, facilities, peer and professional organizations, and insurers of violations of the regulatory provisions governing the profession of a practitioner, of settlements and court actions, and of adverse actions taken by facilities related to a professional's practice.

Self-reporting is required of any licensed health professional who has been the subject of a loss of privileges in a facility, loss of employment due to alleged incompetence, negligence or impairment, the subject of an adverse judgement or settlement arising out of professional liability claims, or who has been convicted of any misdemeanor or felony.

Licensees must report any person within their own profession if they believe that person has committed acts indicative of gross incompetence, a pattern of negligent conduct, unprofessional conduct, impairment, or other violations of laws or regulations.

Licensees must report any person in another health profession if they believe that person committed acts indicative of gross incompetence or practice while his or her ability is impaired by alcohol, drugs, or a physical or mental disability.

The regulations specify when reports must be made, what information is required, and what constitutes a reportable settlement. The regulations also set out the penalty for failure to report. The Nebraska Department of Health will provide forms for reporting.

STUDY OF UNIFORM LICENSURE LAW

A study of the Uniform Licensure Law (ULL) will be the basis of the State of Nebraska's strategy to address professional licensing issues over the next two years. The Nebraska Department of Health will coordinate a review of the ULL, which will include an

examination of existing licensure processes, the roles of examining boards, the Department of Health, the Office of the Attorney General, licensees and consumers in assuring quality health care. The project will be contracted to a nationally recognized professional organization and is expected to take 18 months to complete. If legislative changes are found to be needed, they will be submitted for consideration for the 1997 Legislative Session. The Department of Health currently licenses and regulates 26 health professions.

X-RAY SYSTEM OPERATORS AND LIMITED X-RAY SYSTEM OPERATORS

In 1987 the Radiation Control Act was amended to provide for the certification of diagnostic X-ray equipment operators. The regulations to implement this legislation were completed in 1990. Because courses of instruction for limited operators were not widely available, no enforcement actions have been taken against those not in compliance.

There are now three courses of instruction and an interactive "distance education" opportunity for limited x-ray system operators in the state. Consequently, enforcement of education and training requirements for operators of diagnostic X-ray systems will begin September 1, 1994.

To give facilities time to comply, a policy for phase-in of implementation as to limited x-ray system operators has been developed. From September 1, 1994, to August 31, 1995, facilities that are cited for utilizing non-certified limited x-ray system operators may provide a corrective action plan which includes documentation that the individual is enrolled in an approved training course. The facility must also state a reasonable date by which this individual will have completed the course and passed the required examination. The corrective action plan must be approved by the Division of Radiological Health. This individual would be allowed to continue taking x-rays during the agreed-upon time period.

Beginning September 1, 1995, facilities that are cited for utilizing non-certified limited x-ray system operators will no longer be allowed to continue to use those individuals for radiography until they are certified, unless the individual is enrolled in an approved course of instruction at the time of the inspection.

Beginning September 1, 1996, facilities that are cited for utilizing non-certified limited x-ray system operators will no longer be allowed to continue to use those individuals for radiography until they are certified.

For x-ray system operators, beginning September 1, 1994, facilities that are cited for utilizing non-certified x-ray system operators will not be allowed to use those individuals for radiography until they are certified.

The Department of Health will continue to work with all interested parties to reach consensus on several outstanding issues related to training and testing requirements in the current regulations and to support any necessary legislative changes. The goal is a workforce of limited x-ray system operators that is both highly qualified and widely available throughout Nebraska.

GRANTS FOR RURAL HEALTH CARE DELIVERY NETWORKS

The Department of Health's Office of Rural Health has been awarded $800,000 by the Robert Wood Johnson Foundation to bring more health care professionals to rural areas and to make them more accessible to people in sparsely populated parts of the state.

Nebraska was one of only ten states chosen to receive a grant. It is in the second year of funding. The first phase of the grant initiated the development of three community health care networks, linking medical resources in the Panhandle, the Cambridge/McCook region, and the Albion/Ord region.

This funding will enable the Office of Rural Health to provide in-depth technical assistance to the three networks to recruit and retain primary care professionals, to examine managed care, quality assurance and other issues pertinent to health care in the regions, and to help physicians' offices evaluate the management of their practices. The three networks will serve as statewide models for other rural areas trying to establish and support their own networks.

In addition, the Office of Rural Health will look at forming a statewide "locum tenens" program that will supply physicians, nurse practitioners and physician assistants on a short-term basis to relieve professionals in rural areas for vacations and continuing education.

The Office of Rural Health will be eligible to apply for funds to make loans available to expand clinics in medically underserved rural areas.

MATERNAL AND CHILD HEALTH BLOCK GRANT AWARDS

The Nebraska Department of Health has awarded $3.3 million of the Maternal and Child Health Block Grant from the U S. Department of Health and Human Services to programs to improve the health of mothers and children in Nebraska.

The Department of Health seeks to improve the health of mothers and children by assessing and understanding their health care needs, assuring that needed services are available, and supporting the development of sound public health policy.

The recipients and the award amounts:

Central Nebraska Community Services .. $300,000
to serve a 22-county area in north central Nebraska, and assure that eligible children are receiving wellness services; to conduct a needs assessment and conduct public health planning

Panhandle Community Service, Gering .. $136,258
to conduct an awareness campaign in English/Spanish on the importance of prenatal care and the services available, and to improve access to prenatal care provided by physicians

Douglas County Health Department $106,180
"Childhood Lead Poisoning Prevention Program" to conduct an outreach program to take information about lead poisoning into neighborhoods

Douglas County Health Department $51,984
"Maternal and Child Health Leadership Initiative" to coordinate needs assessment activities in Douglas County and assure an MCH system responsive to needs of families.

Lincoln/Lancaster County Health Department $85,000
"Maternal and Child Health Promotion Program" to connect participants in a referral network, and provide public health nursing services in the home, to coordinate services between agencies.

Adams County Child Development Council and Mary Lanning Memorial Hospital, "Healthy Beginnings" $90,000
to provide home visitation in rural areas and promote comprehensive network of care for women, infants, children and adolescents

Good Samaritan Hospital Foundation $33,310
"Teen-Net Health Education" to provide prenatal and parenting information to pregnant teens

Hispanic Community Center, Lincoln $38,100
to provide mental health services and referrals to Hispanic families

Indian Center, "Prevention Programs for Teens" $32,591
to provide educational services to Native American youth

Lutheran Family Services $80,000
"Maternal Health Care Project- Dawson and Lincoln Counties"
to coordinate prenatal care services for high-risk women

Nebraska Association of Farmworkers $121,504
Multicultural Human Development Corporation (Lexington, South Sioux City, Grand Island and Lincoln) "Hispanic Health Care Access Project," targets Hispanic/Latino women, children and youth in a five-county area to improve their access to health care

Visiting Nurse Health Services $28,430
"Maternal Child Health in Shelters Program"
to offer nursing services at 7 shelter sites and ensure that women and children have access to medical care

YWCA, "Survival Skills Program, "Lincoln .. $39,879
to support family life, health education and self-esteem enhancement for adolescents through activities, home visits and counseling

University of Nebraska Medical Center.. $267,315
"Statewide Network for Children with Special Health Care Needs"
to provide clinics and a toll-free line to reduce infant mortality through prevention of birth defects

University of Nebraska Medical Center..... $48,870
"Community-Based Follow-up Clinic"
to provide parent education and referrals to families with infants at high risk for developmental problems

University of Nebraska Medical Center.. $274,613
"Maternal Care Program"
to provide direct prenatal care to medically underserved women

University of Nebraska Medical Center.. $705,000
"Child Health Clinics Project"
to facilitate medical care for low income children across clinic sites which include Charles Drew Health Center, Creighton University-Department of Pediatrics, Douglas County Health Department, Indian-Chicano Health Center, University of Nebraska Medical Center-Department of Pediatrics, and the Urban Indian Wellness Center

Nebraska Urban Indian Health Coalition .. $20,000
to develop a system to identify Native American populations in Lincoln that are underserved by health care

Omaha Housing FirstStep $20,000
"Young Fathers Program"
to assist young men from diverse cultural population in transition to adulthood by enhancing their abilities to meet the demands of fatherhood

University of Nebraska-Lincoln $16,236
"High-risk Maternal Follow-up"
to develop and test a nutrition screening tool to identify high-risk pregnant women

Winnebago Tribe $18,500
to address substance abuse in grades K-12

University of Nebraska Medical Center..... $19,557
to increase understanding of barriers for low-income families to participating in health care system and to provide baseline information to monitor impact of managed care and health care reform

University of Nebraska Medical Center..... $10,000
to support Rural Partnership for Children Project

Nebraska Department of Social Services, "Medically Handicapped Children"s Program" $771,152
to provide medical assessment of special needs children through clinics held across the state, payment for services, and case management

EMERGENCY MEDICAL SERVICES

LB 1210, passed in the last legislative session, allows first responders to operate automatic defibrillators. The first responder service must have a physician-approved protocol and operate under the supervision of a medical director. This change will make automatic defibrillation more available in rural parts of the state.

DIABETES GRANT

The Nebraska Diabetes Program has received a five-year grant award from the Centers for Disease Control and Prevention. This grant will focus on patient and professional education on diabetes in a 21-county area in western Nebraska. It will include an awareness campaign that encourages screening for diabetes and promotes proper control for those who have diabetes. This will be a community-based, grassroots effort with the formation of coalitions, including minority representation, to support the goals of the grant.

5 A DAY FOR BETTER HEALTH

The Department of Health is taking part in the "5 A Day for Better Health" Program, which is a cooperative effort with the National Cancer Institute and the Produce for Better Health Foundation, Inc. The program seeks to communicate the benefits of consuming at least five servings of fruits and vegetables daily as part of a diet low in fat and high in fiber. The goal is to increase per capita consumption of fruits and vegetables from the current 2.5 servings per day to 5 per day by the year 2000.

WIC STRATEGIC ISSUES IDENTIFIED

The Nebraska Women, Infants, and Children (WIC) Program held a strategic planning meeting in July to

discuss major issues facing WIC for the future. The meeting participants set priority goals for the WIC Program, including: 1) beginning a large scale public relations effort, 2) finding out from WIC clients how the program can better meet their needs, and 3) becoming integrated with other community programs and resources. State and local program staff are now working to identify strategies for accomplishing the goals, developing a work plan and assigning responsibilities for implementation.

I want to express my appreciation to the Nebraska Medical Association for its sponsorship of HealthQuest at the 125th anniversary of the Nebraska State Fair and for its active and unflagging support of the Every Woman Matters Program.

Respectfully submitted,
Mark B. Horton, M.D., M.S.P.H.
Director of Health

REPORT OF THE NEBRASKA DEPARTMENT OF SOCIAL SERVICES

The Nebraska Department of Social Services is pleased to submit this report to the Nebraska Medical Association for review at the September 1994 meeting of the Board of Councilors and House of Delegates. While the primary focus of this report will be on the Nebraska Medicaid Program, additional information related is being provided on other recent activities within the Department which may be of interest to your organization.

NEBRASKA MEDICAID

MEDICAID BUDGET

Nebraska Medicaid expenditures for FY94 totalled $586 million, with the general fund (GF) portion at $203 million. This is an increase of 10.7% over last year's Medicaid expenditures of $529 million with general funds at $196.5 million of the total. (See attachment A)

The GF increase from FY93 to FY94 was 3.3%, down from a GF increase from FY92 to FY93 of 40.7%, and a GF increase from FY91 to FY92 of 11.3%.

The reduced Medicaid expenditure rate for FY94 has resulted in a carryover of $1.1 million (GF). It is important to note that this carryover represents just over 1/2 of 1% of the available funds.

The small increase in FY94 expenditures over FY93 expenditures was the result of a variety of internal and external factors. We believe the major contributing factors to be:

1) STABILIZATION OF THE NUMBER OF PERSONS ELIGIBLE FOR MEDICAID

   In FY94, an average of 135,160 persons were eligible each month. This is slightly less than a 1% increase over FY93. The increase in average monthly eligibles from FY92 to FY93 was 9.6%.

   It is important to note that even though the overall Medicaid population did not increase substantially, we have experienced large increases in certain eligibility groups. For example, persons with disabilities increased 11.2% from FY93 to FY94.

2) PSYCHIATRIC EXPENDITURES FOR CHILDREN

   Medicaid psychiatric care related expenditures for all children in FY94 totalled $44.2 million. This is a 10.5% increase over last year. The increase from FY92 to FY93 was 56.9%.

   Inpatient Psych expenditures for all children in FY94 totalled $29.8 million. This is an increase of 2.1% over last year. The increase from FY92 to FY93 was 52.6%.

   The number of children currently in hospitals for psychiatric care has been reduced by over 50%.

3) The national health care inflation rate was last indicated to be 5.9% annually, down substantially from recent years.

NEBRASKA MEDICAID MANAGED CARE PLAN

The Medicaid Managed Care plan was approved by the Managed Care Commission and forwarded to the Governor, earlier this year.

The Governor has instructed, along with the recommended primary care case management system reimbursed by fee-for-service, and administered by the Department of Social Services, that administration of the Plan be open to competitive bidding by outside providers. It has also been recommended by the Governor that a capitated reimbursement system be evaluated. The Alexander and Alexander Consulting Group of Chicago, Illinois, has been selected to prepare a Request for Proposal to solicit competitive bidding for administration of the Plan and a possible capitation component.

The vendor(s) selection date will be in November, 1994.

UPDATE TO LB 805

LB 805, passed in 1993, imposed a yearly tax of $100 on each physician licensed in Nebraska. Funds raised under this tax were credited to the general fund and used to increase fees paid to physicians for primary care services paid under the Medical Assistance Program (Medicaid).

The Medicaid payment rates for primary care procedure codes were increased for dates of services beginning 10-01-93. As a result of this increase, expenditures for the primary care procedure codes as of June 30, 1994, were $693,966.50.

There was an underexpenditure of these additional funds allocated for FY93-94, and some underutilization of services. The Department anticipates another increase in physicians fees for primary care services again in October 1994. Physicians will be notified of those increases at the time they occur.

MEDICAID ESTATE RECOVERY PROGRAM

Under the mandates of OBRA 93, the General Counsel, Public Assistance, and Third Party Liability units, working cooperatively, have implemented a Medicaid Estate Recovery program. State statutes were enacted by Section 39 of LB 1224 which was effective July 16, 1994.

Under estate recovery, the Nebraska Department of Social Services will recover Medicaid costs from the estates of certain former recipients. The law requires the agency to recover Medicaid expenditures in the following circumstances:

1. If the decedent (deceased individual) was fifty-five years of age or older at the time Medicaid was provided.

2. The decedent resided in a nursing facility or other medical institution. The Agency WILL NOT seek recovery if the decedent is survived by: (A) a spouse, (B) a child who either is under 21 years of age, or is blind or disabled (SSI/AABD), (C) the value of the decedent's estate is less than $5,000.

Only the costs of services provided after July 16, 1994, will be recovered.

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) program is a new federally funded and state operated vaccine supply program tentatively scheduled for October 1, 1994. The program will supply federally purchased vaccines at no cost to all public health care providers and to private health care providers who agree to participate in the program.

Children who are eligible to receive VFC-provided vaccines include: (1) children enrolled in Medicaid; (2) children who do not have health insurance; and (3) children who are American Indian or Alaskan Native. Also, children who have health insurance which does not cover vaccines can receive VFC-provided vaccines at community/migrant health centers and rural health clinics.

The current Medicaid vaccine program operating in Nebraska will be phased out as the VFC program becomes operational. Current providers will receive enough vaccine from the Medicaid program for the remainder of 1994.

Billing for the VFC program will be the same as for Medicaid using the appropriate procedure code with a 52 modifier to claim the administration fee. The vaccine administration fee is expected to be raised to encourage participation, but the amount has not yet been determined.

A public hearing will be held for public comment on the changes in policy as they relate to the new vaccine program.

Physicians and Professional Associations will receive notice of the dates and times of the public hearing, as they become available.

MEDICAID PHARMACY (DRUG) PAYMENT SYSTEM

In June of this year, the Department of Social Services issued a request for proposal to solicit bids from qualified vendors to enhance the State's pharmacy claims processing system. The selected vendor will be responsible for implementing and operating an automated eligibility verification system, electronic drug claim capture system, as well as a sophisticated prospective drug use review program.

The response to this request for proposal has been overwhelming. The Department expects that a contract will be awarded in October and that it will be operational in the first quarter of 1995. The technology utilized is very similar to that currently used by the bank card industry and will enable pharmacy providers to submit drug claims in a paperless environment. Eligibility and coverage will be immediately verified and the claim will be adjudicated. The entire process will occur within 7 seconds from the time the claim is submitted. In addition, all drug claims will be routinely reviewed for duplication (i.e., clients who are receiving the early refills, underutilization, as well as serious drug interactions). The Department believes that when operational, the system will enable physicians and pharmacies to better serve the Department's clients.

HUMAN SERVICES

FAMILY CHILD CARE HOME REGULATIONS FOCUS ON SAFETY

The anticipated implementation date for the new Family Child Care Home I and II Rules and Regulations with enhanced health and safety regulations is October 1, 1994.

Consideration is being given to developing specialized rules and regulations for child care centers that serve children who are mildly ill. There are unique health and safety issues related to this type of child care service.

Review and revision of child care center regulations and possibly Preschool regulations that would enhance the health and safety of children has begun. A process has been developed which parallels that which was used for Family Home Regulations, including statewide public meetings and hearings. Implementation is not expected until at least the summer of 1995.

FOSTER FAMILY LICENSING

The Department of Social Services and the Nebraska Commission for the Protection of Children facilitated the revision of Nebraska's foster family home licensing regulations.

A committee that included foster parents, placement agency staff, former foster children and representatives of biological parents was called together to advise the Department of Social Services on the development of the new licensing regulations. The committee met a number of times and their recommendations were shared with all Nebraska foster parents and other interested parties. Public meetings were held across the state to allow a dialogue between interested parties and representatives from the Department of Social Services. Comments from those meetings were then incorporated into what will become the final draft of regulations.

The development of the policy that will supplement the new regulations is underway and once compete, the final draft will be released again for public comment.

Completion of the regulations is anticipated for later this year.

PARTNERSHIPS IN PROTECTING CHILDREN

Staff involved with the Department's Child Protective Services and Foster Care programs have been at work on a redesign of the Department's child welfare program for over a year. The first phase of this project included selection of staff by their peers and contacts with over 1,000 internal and external customers from across the state. A philosophical base was developed during the first phase of work. This base emphasizes the Department's commitment to preserving families while keeping the safety of the child as the primary consideration and an understanding that DDS is only one part of a broader community system which addresses child welfare issues. This base also supports the importance of family responsibility and opportunity by active engagement of the family decision-making.

The second phase of the redesign project has focused on defining policy — "what" the child welfare work of the Department would be. The third phase focused on "how" child welfare work would be done by the Department — through the development of guidebooks for practice. Throughout its work, the Redesign Steering Team has emphasized reduction in the layers of approval required by policy and has striven to move decision-making as close to the customer as possible. The Team has also worked to define the supports which will be needed to do the work as it is redesigned. Increased use of teams and enhanced consultation are seen as critical to successful work. Enhanced legal support is also seen as a high priority. Additional information regarding the child welfare redesign initiative will be available through individual and community briefings.

FAMILY PRESERVATION AND SUPPORT SERVICES

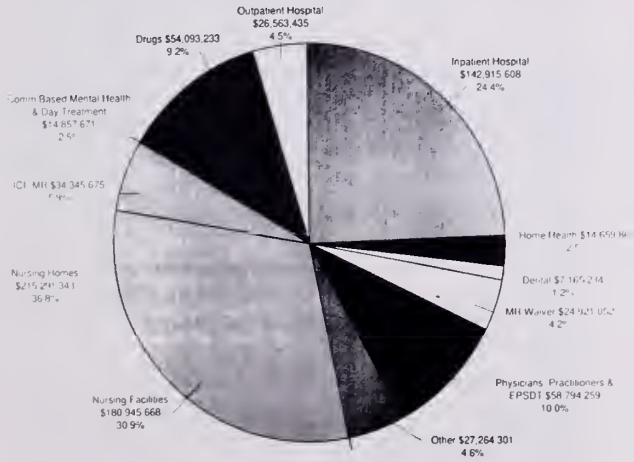
A new Part 2 was added to Title IV-B of the Social Security Act by the Omnibus Budget Reconciliation Act of 1993. Entitled "Family Preservation and Support Services", this new program provides capped entitlement funding to state child welfare agencies for the purpose of encouraging and enabling each state to develop and establish, or expand, and to operate a program of family preservation services and community-based family support services. Funding will be available to states for Fiscal Years 1994-1998. First year funding is to be used primarily for planning purposes. To qualify for funding during Fiscal years 1995-1998, states must develop a five-year plan for family preservation and support services.

Governor Nelson has asked the Commission for the Protection of Children to take the lead in implementation of the Family Preservation and Support Act in Nebraska. The Commission has formed a Planning Task Force comprised of 40 individuals from across the state representing a broad range of professional, cultural, racial, and geographical areas/groups. A statewide videoconference was held on June 15 to inform the public about the Act and how planning will occur in Nebraska. During the coming year, the Planning Task force will sponsor a series of community meetings to gather input on the five-year plan. The Task Force is also planning to hold a state planning conference to develop action steps to implement recommendations that come out of the community meetings.

Nebraska's grant for Fiscal Year 1994 totals $233,263. Much of this money will be used to support planning at the community level. The Task Force will issue a Request for Proposals this fall to solicit proposals from communities for planning. Grants for Fiscal Years 1995-1998 will be used to fund family preservation and support services in communities.

Respectfully submitted,
Mary Dean Harvey, Director
Nebraska Department of
Social Services

PRELIMINARY MEDICAID VENDOR EXPENDITURES BY SERVICE - FISCAL YEAR 1994



Total Vendor Payments $586,525,937

Prepared by Nebraska Department of Social Services Research Unit 8/18/94

Attachment A

REPORT OF THE AD-HOC COMMITTEE ON LOW LEVEL RADIOACTIVE WASTE DISPOSAL

Merton A. Quaife, M.D., Omaha - Chairholder; Robert G. Osborne, M.D., Lincoln, Board Liaison; Allen D. Dvorak, M.D., Omaha; Rodrigo Gomez-Cordero, M.D., Norfolk; Martin R. Lohff, M.D., Omaha; W. E. Lundak, M.D., Lincoln; David C. McMaster, M.D., Auburn; William H. Northwall, M.D., Kearney.

The Committee continues to monitor activities related to fulfilling requirements of federal and state legislation requiring individual states and/or compacts between states to plan, develop, and operate facilities for the safe and efficient disposal of low level radioactive waste. The Central Interstate Compact and its activities (at this point primarily directed toward licensing of a facility sited in Boyd County Nebraska) are particularly relevant to the Committee's review process as the State of Nebraska is host state. At this time on site storage of low level radioactive waste is required as there is no available site for definitive disposal. The licensing process thus becomes a key factor in timely completion of the facility.

During the interim period, actions related to the evolution of the licensing process have involved Executive, Legislative, and Judicial branches of state governments as well as the Compact's Commissioners. To maintain currency while awaiting further action by the State of Nebraska on the facilities license, the Committee has evaluated the following relevant documents:

- "Disposal of Low Level Radioactive Waste - Problems and Implications for Physicians" JAMA May 12, 1993 Vol. 269 No. 18 pp. 2403-2406.
- Report of Organizations United for Responsible Low Level Radioactive Waste Solutions. "Economic and Employment Benefits of the Use of Radioactive Materials.

In addition, the Committee Chairperson has: 1) Attended the Annual Meetings of the Central Interstate Low Level Radioactive Waste Compact Commission; 2) Met periodically with the Executive Director of the Compact Commission to review and update the progress toward meeting legislative requirements; 3) Maintained liaison with National Medical Organizations (eq. AMA, ACNP, ACR) to monitor issues of Low Level Radioactive Waste Disposal occurring beyond the more parochial interests in the progress of the Central Interstate Compact.

We continue to solicit input from the Nebraska Medical Association members, and encourage your participation in the process of education of our pa-

tients and the public at large on issues related to safe and efficient disposal of low level radioactive waste.

REPORT OF THE AD-HOC COMMITTEE ON MATERNAL AND CHILD HEALTH

Lawrence C. Bausch, M.D., Lincoln - Chairholder; Ronald W. Klutman, M.D., Columbus - Board Liaison; Bruce T. Rowe, Lincoln - MCH Liaison.

SECTION ON MATERNAL MORTALITY REVIEW

G. William Orr, M.D., Omaha, Director; James H. Elston, M.D., Omaha; L. Palmer Johnson, M.D., Lincoln; Charles W. Marlowe, M.D., Omaha; Myrna C. Newland, M.D., Omaha; Terence K. Foote, M.D., Hastings.

SECTION ON FETAL MORTALITY REVIEW

Carl V. Smith, M.D., Omaha, Director; Gary D. Milius, M.D., Lincoln; Daniel G. Bohi, M.D., Omaha; Ernest K. Bussinger, M.D., Scottsbluff; Bruce A. Buehler, M.D., Omaha; Craig A. Bassett, M.D., Omaha.

SECTION ON INFANT MORTALITY REVIEW

Howard W. Needelman, M.D., Omaha; Gerald W. Luckey, M.D., David City; Lawrence C. Bausch, M.D., Lincoln; Fred J. Pettid, M.D., Omaha.

SECTION ON CHILDHOOD MORTALITY REVIEW

Gregg F. Wright, M.D., Lincoln, Director; David P. Schor, M.D., Lincoln; Jon A. Vanderhoof, M.D., Omaha; Clarence Davis, Jr., M.D., Osceola.

Paige Charleston, Omaha
Lynn A. Davidson-Stroh, Omaha
Melinda Fiedor, Omaha
Angela King, Omaha

The Ad-Hoc Committee on Maternal and Child Health has met once during the summer and invited Mr. Stan Cooper, the Director of the Bureau of Vital Statistics, to the meeting. Mr. Cooper's report included an update on the development of electronic reporting of birth certificates to the state which should improve the timeliness and accuracy of such information. It was again noted that physicians will not be required to sign birth certificates in the future but may do so if they so choose. Discussion also followed as to the potential for developing a computerized system whereby maternal and child health information can be reviewed by the committee either directly from the NMA office by having a satellite affiliate or by having a computer available for research purposes at the Bureau of Vital Statistics.

Now that the birth certificate information has been standardized, it is important that we stress that physicians continue to see that the lower portions of the birth certificate are completed as well. This information is now standardized among most states and is currently being reviewed by the Department of Heath and Human Services. From time to time the Department has written the Bureau of Vital Statistics regarding certain outliers of perinatal conditions and is asking the state to respond to these conditions as to their relevance. The Committee has agreed to review some of the relevant outliers of perinatal conditions and to share this review with the Bureau of Vital Statistics and the Department of Health and Human Services.

Doctor Carl Smith has expanded the scope of the review of fetal deaths and his subcommittee is currently in the process of this expanded review of fetal deaths which should be completed by year end. A summary of cases of maternal deaths has been submitted by Doctor Bill Orr to the Nebraska Medical Journal for publication.

REPORT OF THE AD-HOC COMMITTEE ON MEDICAID SERVICES

Christopher C. Caudill, M.D., Lincoln - Chairholder; Patrick E. Brookhouser, M.D., Omaha; Krynn K. Buckley, M.D., Lincoln; Judith A. Butler, M.D., Superior; Allen D. Dvorak, M.D., Omaha; Roger A. Jacobs, M.D., Seward; Dale E. Michels, M.D., Lincoln; Harlan C. Shriner, Jr., M.D., Lincoln; John N. Walburn, M.D., Omaha; Eugene A. Waltke, M.D., Omaha; Wayne K. Weston, M.D., Lexington; Greg Fitzke, Omaha; Melanie Somers, Omaha; Christina Closken, Omaha.

The Ad-Hoc Committee on Medicaid Services presents this report to the House of Delegates for its approval.

Representatives of the Association met with representatives of the Nebraska Department of Social Services for purposes of discussing items of mutual interest. Ms. Mary Dean Harvey reported that Alexander and Alexander was in the process of developing the format for the request for proposal in order that bids could be made to the Department of Social Services regarding the Medicaid Managed Care Plan. She indicated that after review by the Department, the Governor will then review and approve or deny the proposals.

It was pointed out to the Association representatives that the Department of Social Services would need to expand its staff and computer capabilities to facilitate the managed care program. We discussed the feasibility of having another group outside the Department monitor the managed care contract that is ultimately signed and Ms. Harvey indicated that the Department is required to provide this monitoring service. She did note, however, that she welcomes reviewing the request for proposal in that the review will help determine ways the Department can administer the managed care plan to provide maximum service for the least cost possible.

Association representatives asked what federal standards are specified for managed care plans and Ms. Harvey indicated that there are very few standards the Department of Social Services must utilize relative to federal regulations. She also indicated that most statutes governing managed care systems originate at the state level.

Association representatives were also informed that the American Nurses Association had reviewed Nebraska's managed care plan and commented that they had not seen a program as well developed as is Nebraska's.

The Association representatives informed the Department of Social Services that the House of Delegates had directed that the committee monitor the co-payment system and its effects on access. The Department of Social Services representatives indicated that through the reduced payment to providers, the Department had saved, as of June 30, the amount of $47,559. Department staff indicated that the initial estimates for provider savings had been approximately $1.1 million which would mean that these quarterly figures should be around $250,000. The staff indicated that they would be investigating these figures in depth in the near future.

It was also pointed out that the escrow account for drug co-payment services had accumulated $299,880 for the same period of time. It was noted that there will be a 1994 report regarding the co-payment requirements and that the report will include informa-

tion on the impact of co-payments as experienced by customers, providers and the agency along with other reporting requirements. The report will be issued by December 1, 1994. It was noted that the Department is considering some type of survey to determine how the co-payment system is functioning and to also include data regarding the rate of co-payment collection by providers. The Association offered its support and assistance to the Department regarding the carrying out of the survey. As of the writing of this report, the Department of Social Services staff indicates that a draft of the survey has been developed and, following further refinement within the Department, the NMA will be provided a copy for review and comment.

Association representatives also discussed the co-payment relative to primary care physicians and as it pertains to how the Department defines primary care providers. Department staff reported to the committee that obstetricians and gynecologists are utilizing the system of the co-payment for non-pregnancy related care and that children under the age of 18 are not charged the co-payment. Department staff did indicate that if OB/GYN physicians who believe their services are primary care in nature were available around the clock for all types of primary care services, the Department might look more favorably as considering this specialty field as primary care physicians.

The Association representatives also discussed with the Department staff whether there is any indication that providers may be dropping out of the Medicaid system due to the inconvenience of the co-pay mechanism. Department staff indicated that they were monitoring this situation and thus far had had no indication of that happening. It was also noted by Department staff that the issues related to the co-payment would disappear when the managed care system is implemented.

Department staff also reported that, at the time of the meeting, the Medicaid budget was within its means and they foresaw or anticipated no deficit for the year. Department staff did indicate that some of the practice management teams have had a great impact on the cost of care. Association representatives pointed out to the Department of Social Services staff that about 500 physicians have dropped their Nebraska license based on the $100 annual physician licensure assessment.

The Ad-Hoc Committee on Medicaid Services will continue to monitor Nebraska's Medicaid program, represent the Association's interests regarding the Medicaid program, and provide follow-up reports to the House of Delegates.

REPORT OF THE AD-HOC COMMITTEE RE: MEDICARE

Paul E. Collicott, M.D., Lincoln - Chairholder; Herbert A. Hartman, Jr., M.D., Omaha - Board Liaison; Alvin A. Armstrong, M.D., Scottsbluff; Richard A. Blatny, M.D., Fairbury; Michael J. Duggan, M.D., Lincoln; David H. Filipi, M.D., Omaha; Kiran Gangahar, M.D., Lincoln; J. A. Grubbe, M.D., Lincoln; Loren H. Jacobsen, M.D., Broken Bow; Alan W. Langvardt, M.D., Beatrice; Dwaine J. Peetz, M.D., Neligh; Richard M. Pitsch, Sr., M.D., Seward; Richard A. Raymond, M.D., Omaha; Steven R. Thomas, M.D., York; Scott Stuart, Omaha; Erika Ketteler, Omaha; Amy Trelease-Bell, Omaha.

The Ad-Hoc Committee Re: Medicare provides the following information to the House of Delegates.

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL
CODING OF PHYSICIAN SERVICES

June Gibbs Brown
Inspector General
May 1994
OEI-03-91-00920

EXECUTIVE SUMMARY

PURPOSE

This report describes vulnerabilities in the maintenance, use, and management of the Current Procedural Terminology Codes, Fourth Edition (CPT-4), as they relate to Medicare reimbursements.

BACKGROUND

The Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) is a three-part procedure labeling system used to identify services in the Medicare Part B program. Current Procedural Terminology (CPT-4) codes identify physician services and comprise the first level of HCPCS. The HCPCS also identifies other services such as ambulance services and durable medical equipment. Since January 1992, HCFA has assigned a relative value unit (RVU) to each CPT-4 code to represent the resources that each service requires. The RVU is now used as the basis to set reimbursements for health care providers. The reimbursement amount for each code is contained in the Medicare Fee Schedule. In Fiscal Year 1991, HCFA paid $36.2 billion for 867 million services claimed under CPT-4.

The CPT-4 is a systematic listing of descriptive terms and identifying codes used to describe the services of health care providers. It was developed by the American Medical Association (AMA) in 1966. Now in its fourth edition, CPT-4 contains approximately 7,000 codes, each in a five-digit numerical format. In February 1983, HCFA incorporated CPT-4 into HCPCS.

METHODOLOGY

We reviewed both the CPT-4 system itself and HCFA's management of the system as they affect Medicare expenditures. We conducted this inspection in two phases. In the initial phase, we gathered documentation. We first compiled 25 reports on CPT-4 related topics; most were issued by the Office of Inspector General. Other sources included HCFA, the Physician Payment Review Commission, and the General Accounting Office (GAO). We then contacted 41 medical specialty societies, 12 Medicare carriers, the AMA, the American Health Information Management Association, the American Hospital Association, the Blue Cross Blue Shield Associaiton, and the Health Insurance Association of America. We asked each to provide documentation concerning pertinent CPT-4 issues. We also obtained additional material from an on-line search of a data base of medical journals. These articles ranged from descriptions of studies with developed methodologies to discussions of expert opinions. A companion report, *A Compendium of Reports and Literature on Coding of Physician Services, OEI-03-91-00921,* provides a detailed summary of each document.

In the next phase, we conducted structured interviews to refine the issues we had developed. We interviewed representatives from each group previously contacted except for GAO. In addition, we spoke to 23 coders and coding consultants. Our range of respondents ensured a fair representation of professional opinions and experience.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Incorrect coding affects Medicare reimbursement and causes inequities in payment under the Medicare Fee Schedule.

Flaws in CPT-4 codes, guidelines, and index can lead to improper coding.

- Examples illustrating code flaws occur in most sections of CPT-4.
- Problems in CPT-4 guidelines and index also contribute to incorrect coding.
- Some respondents have criticized the process that AMA uses to consider changes, additions, and deletions in CPT-4.

The AMA and HCFA have both taken some corrective measures to address coding problems.

The methods by which HCFA has incorporated CPT-4 into Medicare's coding system do not ensure appropriate reimbursement to Medicare providers.

- The HCFA has not developed criteria or communicated decision rules to the CPT-4 Editorial Panel for use in changing, adding, or deleting codes in light of the Medicare Fee Schedule's requirements.
- The HCFA has not adequately communicated Medicare coding policy to providers.
- The HCFA has not developed an efficient or effective process for establishing RVUs for new or modified codes.

A proliferation of CPT-4 changes will undermine HCFA's ability to contain expenditures under the Medicare Fee Schedule.

RECOMMENDATIONS

We recommend that HCFA:

- Produce and promulgate to the AMA and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system and encourage them to apply the objectives in the development of new or revised codes;
- Apply HCFA coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule;
- Work with the AMA, Medicare carriers, medical speciality societies and other related parties to develop a mechanism that assures a unified and consistent dissemination of guidelines on how to use and interpret codes.
- Evaluate the current process for implementing changes to the Medicare Fee Schedule. This includes: (1) developing an effective process for establishing work values for new or revised codes, (2) communicating to the AMA the number of annual additions, deletions, and revisions to CPT-4 that HCFA could effectively review, and (3) delaying implementation of new or revised codes, except for new technologies, until reliable data is available to predict service utilization.

We recommend that AMA:

- Consider and encourage medical specialty use of HCFA coding objectives and criteria in the development of new or revised CPT-4 codes;
- Consider a review of the CPT-4 index within the framework of its own commissioned study's recommendations;
- Work with HCFA to develop a mechanism that assures a unified and consistent dissemination of Medicare coding policy;
- Provide HCFA with utilization estimates for new or revised codes; and
- Work with HCFA to arrive at an acceptable number of annual CPT-4 code changes to allow for proper HCFA evaluation.

COMMENTS

The HCFA and AMA commented on the draft reports. The full text of their comments appear in Appendix E. The HCFA concurred with the second and fourth recommendations and are considering the first and third. Although the AMA expressed concern about the study methodology, they found all but recommendation five to be fair and reasonable. The AMA does not believe that putting a "cap" on the number of CPT-4 changes per year is in the best interest of the Medicare program, its beneficiaries, or medicine.

We recognize the complex nature of the CPT system and commend HCFA and the AMA for their willingness to take the necessary corrective actions to improve the coding process and assure the successful implementation of the Medicare Fee Schedule.

REPORT OF THE COMMISSION ON LEGISLATION & GOVERNMENTAL AFFAIRS

Allen D. Dvorak, M.D., Omaha - Chairholder; Ronald W. Klutman, M.D., Columbus - Board Liaison; Krynn K. Buckley, M.D., Lincoln; Judith A. Butler, M.D., Superior; Paul E. Collicott, M.D., Lincoln; Susanne E. Eilts, M.D., Omaha; James A. Fosnaugh, M.D., Lincoln; Benjamin R. Gelber, M.D., Lincoln; Charles D. Gregorius, M.D., Lincoln; Robert D. Harry, M.D., Lexington; Herbert A. Hartman, Jr., M.D., Omaha; Linda S. Head, M.D., Bellevue; David J. Hoelting, M.D., Pender; D.G. O'Leary, M.D., Omaha; George W. Orr, M.D., Omaha; Robert G. Osborne, M.D., Lincoln; Michelle B. Petersen, M.D., Lincoln; C. Lee Retelsdorf, M.D., Omaha; Blaine Y. Roffman, M.D., Omaha; Robert F. Shapiro, M.D., Lincoln; Duane Sherwin, M.D., Norfolk; Eileen C. Vautravers, M.D., Lincoln; Timothy O. Wahl, M.D., Omaha; Peter J. Whitted, M.D., Omaha; Dorothy A. Zink, M.D., Omaha; Mark Buchanan, Omaha; Katherine Clark, Omaha; Steve Goebel, Council Bluffs; Robert R. Kahnk, Omaha.

The Commission on Legislation and Governmental Affairs presents the following report to the House of Delegates for its consideration. The Commission plans to meet in October for purposes of addressing various legislative issues that we anticipate will come before the 1995 Nebraska Legislature when it convenes on January 4.

The Commission will again utilize a physician contact list for all senators which will be finalized following the November election. In addition, a major role

in legislative contact is undertaken by the individual members of the Association and the membership of the Alliance. The local contact by Association members and Alliance members in the senator's district is extremely important and strongly encouraged by the Commission. We encourage physicians and their spouses to be active in the November election, communicating with the candidates you support, and to assist in the campaign to the extent possible.

When the Commission meets in October, we will specifically address the willing provider issue, and the matter of whether to introduce legislation dealing with informing breast cancer patients of alternative, efficacious methods of treatment. We will also discuss legislative issues which we expect to face in 1995, including proposed changes in the scope of practice for nurse practitioners and nurse midwives, modification of the state regulation of limited-scope x-ray operators, the biennial Medicaid budget (including continuation of copayments and the physician surcharge), and state issues arising out of any federal health care legislation which may be adopted by Congress.

The 1995 session of the Legislature will be a 90-day session which we anticipate will adjourn in early June. The legislative issues of importance to the Association will again be carried in various issues of the Association newsletter. We encourage the involvement of all Association and Alliance members as we strive to represent the best interests of all physicians.

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

Rodney S. W. Basler, M.D., Lincoln - Chairholder; Herbert A. Hartman, Jr., M.D., Omaha - Board Liaison; David E. Borg, M.D., Falls City; H. Jeoffrey Deeths, M.D., Omaha; Benjamin R. Gelber, M.D., Lincoln; John J. Hoesing, M.D., Omaha; Glen F. Lau, M.D., Lincoln; Michael J. McGahan, M.D., Lincoln; Scott Neumeister, Omaha; Scott Shipman, Omaha.

The Commission has been extremely active over the last several months while acting as the focal coordinating body for NMA participation in the "Health Quest" program at the Nebraska State Fair. Coverage of the NMA booth, as well as speakers and screening sessions, have been arranged to make a very positive presence for organized medicine as part of this event.

The Commission has completed development of a packaged slide program for members to use in discussing health care reform with the public. We recognize that the membership receives ongoing requests from service clubs and other community organizations to discuss this topic and believe that the availability of a set of slides and series of talking points regarding each slide encourages the membership to take advantage of these opportunities to bring our message to the public.

During this year, the Chair of the Commission continued to meet with the NMA President, the Executive Director, Assistant Executive Director, and our public relations team to investigate potential areas to focus our energy and resources to enhance the public relations functions of the NMA. I believe we presently have an extraordinarily talented and responsive group of people in place, who are prepared to instantly confront any challenge presented them.

The Commission has continued its regular responsibilities including providing the state-wide press with an annotated pre-release copy of the **Nebraska Medical Journal**, and producing "Health Tips" for Nebraska radio stations and newspapers. These short press releases, discussing areas of general health interest, are provided monthly and are utilized by radio stations and newspapers. Usage of this material by Nebraska's print media continued to increase in 1994. The Commission also distributes taped health messages from the NMA President.

REPORT OF THE NMA PRO OVERVIEW COMMITTEE

Herbert A. Hartman, Jr., Omaha - Chairholder; David L. Bacon, M.D., Kearney; Gary W. Barth, M.D., Hastings, Dennis M Connolly, M.D., Lincoln; Doak P. Doolittle, M.D., Holdrege; Glen A. Forney, M.D., Scottsbluff; C.T. Frerichs, M.D., Beatrice; Thomas F. Gallagher, M.D., Omaha; Richard E. Jackson, M.D., Pawnee City; Tamara R. Johnson, M.D., Cambridge; M. Jack Mathews, M.D., Lincoln; John L. Reed, M.D., Lincoln; Thomas Blee, Omaha; Thomas Rishavy, Omaha; Thomas Sullivan, Omaha.

The PRO Committee met on June 30, 1994, with representatives of Sunderbruch.

Item #1 - Discussion of Resolution #18 which was passed by the House 4/94 requesting the 1-800 number was discussed. The consensus of the committee was that the NMA does not need to establish an 800 number either for the PRO or in general.

Item #2 - Sunderbruch representatives then discussed the Fourth Scope of Work. Projects are similar to that outlined in the report to the House in April of 1994. These include evaluation of DRGs by hospitals, assessment of radical prostatectomy in elderly males and the start of a deep venous thrombosis prophylaxis in orthopedic surgery.

Item #3 - An issue of concern was raised in the Committee during discussion with Sunderbruch representatives. That issue was the decision and implementation of practice parameters by which to judge quality. No consistent method of application of practice parameter guidelines was present for use by Sunderbruch. The consensus of the Committee was that the whole issue of development of practice parameter guidelines and implementation in terms of quality review and reimbursement should be studied by the Nebraska Medical Association.

Item #4 - The Committee has not received any physician disciplinary type of letters during the 1994 calendar. However, the PRO Committee has received numerous communications from the members of the NMA regarding Sunderbruch decisions regarding denials for admission, continued stays and other administrative-type concerns. For the time being the committee will continue to receive such communications and monitor those problems looking for generic issues to deal with Sunderbruch. The Chairman believes that, although the actual implementation of the practice parameter focus review projects has not been applied enough to affect physicians in terms of quality review, it will be happening. When it does happen that physicians receive quality letters, the PRO Committee would like to see them so that new postures with Sunderbruch can be considered.

REPORT OF THE SCIENTIFIC SESSIONS COMMITTEE

Lawrence D. Helmick, M.D., Kearney - Chairholder; Richard H. Meissner, M.D., Omaha - Board Liaison; Lawrence C. Bausch, M.D., Lincoln; David L. Bacon, M.D., Kearney; Sheila S. Ecklund, R.N., Lincoln; Marcia L. Goering, M.D., Columbus; Charles D. Gregorius, M.D., Lincoln; William F. Gust, M.D., Omaha; David A. Katz, M.D., Omaha; James R. Newland, M.D., Omaha; Sally O'Neill, Ph.D., Omaha; Frederick F. Paustian, M.D., Omaha; Lisa L. Strohmyer, R.N., Papillion; Wesley G. Wilhelm, M.D., Omaha; Pete Leonovicz, Omaha; Dave Pinsinski, Omaha; Troy Plumb, Lincoln.

On the 14th of July, the Scientific Sessions Committee met at the offices of the Nebraska Medical Association in Lincoln. At that time, the committee members reviewed the results of the 1994 Annual Session and possible changes and improvements were discussed. The general feeling was that the 1994 meeting was generally a good one, but attendance was not what we had hoped to see.

At completion of the review of the 1994 Annual Session, we proceeded with initially planning for the 1995 Annual Session as well as finalizing some plans for a seminar at the 1994 Fall Session. Our next committee meeting was set at September 29, at which time we will continue development of the 1995 Annual Session.

REPORT OF THE NMA RADIATION SAFETY WORKING GROUP

Darroll J. Loschen, M.D., York - Chairholder; Charles A. Dobry, M.D., Omaha; Allen D. Dvorak, M.D., Omaha; Ronald W. Klutman, M.D., Columbus; Robert H. McIntire, M.D., Omaha; Frederick F. Paustian, M.D., Omaha; Joseph M. Stavas, M.D., Lincoln; Perry T. Williams, M.D., Omaha.

The NMA Radiation Safety Working Group was appointed to monitor the implementation of the Radiation Safety Act. The most important component of this act (accepting many NMA members who rely upon office radiography to deliver day-to-day care) is the portion of the act codifying the "Limited Services Radiography" concept. Under the act, anyone who utilizes ionizing radiation in any form must first take a course in radiation safety, of at least 16 hours in length. Since there has heretofore been no such course, the Division of Radiation Safety of the State Health Department has made no attempt to enforce this legislation. However, with the development of three courses in "radiation safety" which have been approved by the Division, the Director of the State Health Department has announced (in memo dated 2 August 1994) that this legislation will be enforced beginning 1 September 1994.

For the past two years, the NMA Radiation Safety Working Group has been meeting with representatives of the State Health Department Division of Radiation Safety, the Nebraska Society of Radiologic Technologists, and the Nebraska Radiological Society. It has been the opinion of this working group that a significant amount of progress has been made in reaching a compromise of implementation of this legislation which all can "sign off on". Unfortunately, the 1994 legislative session ended without this group reaching a consensus position.

The Radiation Safety Group met again on 7 July 1994, in an effort to develop a "final" position for the NMA to take in negotiations with the above-mentioned groups. This position can be summarized as follows:

1. Liberal "Grandparenting" of individuals currently operating X-Ray units.
2. Agreement to a $25.00 fee for "Limited Radiographers".
3. Agreement to the original 16-hour course in radiation safety.
4. "Site-specific" certification for those "Grandparented".
5. After this "Grandparenting" period, agreeing to the necessity of passing the "AART" certifying examination.

The Working Group has also requested the Nebraska Radiological Society to consider developing a "proficiency testing" program for limited radiographer offices, patterned after that program developed by the College of American Pathologists for the office laboratory.

The Division of Radiation Safety has also recently sent out a survey to get a better handle on the number of persons actually involved in taking X-rays in the state. Dr. Mark Horton, Director of the State Health Department, has called a meeting of all interested parties, to be held at the State Office Building, on 2 September 1994. The NMA will, of course, be represented at this meeting.

At the time of this report, it is understood that the Nebraska Academy of Family Physicians may be introducing legislation in 1995 which would reiterate the desire for a 16-hour course in radiation safety as the only requirement for "Limited Radiographers" to continue to operate X-Ray equipment.

At the time of the Fall Session, it is hoped that more information will be available to be discussed at the Reference Committee considering this report.

REPORT OF THE NMA ADVISORY COMMITTEE ON NURSING HOME REGULATIONS

Darroll J. Loschen, M.D., York - Chairholder; James G. Carlson, M.D., Lincoln; James A. Fosnaugh, M.D., Lincoln; C.T. Frerichs, M.D., Beatrice; Robert G. Osborne, M.D., Lincoln; T.R. Osborne, M.D., Papillion; John C. Sage, M.D., Omaha; Susan G. Scholer, M.D., Omaha; Tod W. Voss, M.D. Pierce.

The NMA Advisory Committee on Nursing Home Regulations was initiated in 1992 with the advent of implementation of the rather rigorous and onerous regulations accompanying OBRA-87.

Significant liaison was developed between this NMA Committee and the Nebraska Health Care Association (representing most of Nebraska's nursing homes) and also with the State of Nebraska's Bureau of Health Care Facilities.

This Committee has not met since the Annual Session. In fact, at the planning session of the House of Delegates, it was recommended that this **ad-hoc** committee be sunset. It has been noted that recently a state chapter of the American Medical Directors Association has been formed, and that this organization is led by activated NMA members. This organization is also staffed (under contract) by the NMA staff, so it is felt that the interests of the NMA membership will be well-served by this new organization. All NMA members who are involved with care of nursing home patients are encouraged to support this organization, and further information can be obtained by contacting the NMA office.

Similarly, the Advisory Committee for Nursing

Homes, a statutorily-created committee, has recently been reconstituted. The NMA is adequately represented on this committee.

For these reasons, the NMA Advisory Committee on Nursing Home Regulations will be sunset at this time.

REPORT OF THE COMMITTEE ON RURAL HEALTH

Darroll J. Loschen, M.D., York - Chairholder; Ronald W. Klutman, M.D., Columbus - Board Liaison; Richard A. Blatny, M.D., Fairbury; Verlin K. Janzen, M.D., Nebraska City; Kurt E. Johnson, M.D., Ogallala; Tamara R. Johnson, M.D., Cambridge; Donald J. Larson, M.D., Lincoln; Dale E. Michels, M.D., Lincoln; Dwaine Peetz, M.D., Neligh; Richard A. Raymond, M.D., Omaha; Raymond L. Schulte, M.D., Omaha; Michael A. Sitorius, M.D., Omaha; Stephen Stripe, M.D., Humboldt; Danae Browning, Omaha; Bob Chandler, Omaha; Doug Dilly, Omaha; Alan Michels, Omaha.

The NMA's Committee on Rural Health has met once since the Annual Session, on 9 June 1994. Important issues on the table for this committee include:

1. The "Limited Services Radiographer" issue.
2. Nursing Home Regulations.
3. Independent Practice for Nurse Practitioners.
4. Activities of the Greater Nebraska Caucus.
5. Medicaid Managed Care for Rural Nebraska.

The Committee is very interested in the limited services radiographer issue, inasmuch as a great many NMA members from rural areas depend on their in-office X-Ray to deliver quality care. This committee will be very supportive of the efforts of the NMA's Radiation Safety Working Group, and, in fact, many members of the Rural Health Committee also serve on the Radiation Safety Committee.

The issue of nursing home regulations is also of great importance to this group, and it supports the efforts of the newly-formed Nebraska Medical Directors Association.

This committee is very interested in the reasonable and efficient utilization of all mid-level practitioners, especially in the delivery of quality primary care in rural Nebraska. The committee agrees, however, with the NMA's official position that these individuals should function only under the supervision of and in collaboration with fully-licensed physicians. To this end, the Committee has reviewed the NMA's "white paper" on mid-level practitioners and agrees with the concepts put forth in this paper. At its meeting in June, the committee also met with liaison members representing PAs and NPs, and pledged the support of the NMA in educating its members in the appropriate utilization of all mid-level practitioners. To this end, the Committee has requested time at the Annual Session to present a program on this issue, demonstrating that, in fact, the NMA is vitally interested in improving the delivery of care to rural Nebraska, utilizing all available resources in such a way that quality of care will not be compromised.

The Committee supports the efforts of the Greater Nebraska Caucus and applauds its first two "off-session" meetings.

A great deal of time was spent in discussion with representatives of the Department of Social Services, learning about the proposed implementation of Medicaid Managed Care, particularly as it pertains to rural Nebraska. To this end, when the time comes for this implementation, an ad-hoc committee will be formed with representatives from throughout the state to assist the membership with this transition.

REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

Warren G. Bosley, M.D., Grand Island - Chairholder; Robert G. Osborne, M.D., Lincoln - Board Liaison; Joseph R. Ellison, M.D., Omaha; Richard W. Hammer, M.D., Lincoln; Morris B. Mellion, M.D., Omaha; Mylan R. VanNewkirk, M.D., Brule; Wesley G. Wilhelm, M.D., Omaha; Chris C. Madden, Omaha; Steve Phipps, Omaha; Kelli Hanson, Omaha.

The Committee has not met since its report to the House of Delegates at the Annual Meeting. It has not been possible to meet with representatives of educational facilities during the summer months.

On about 7 September, members of the Committee will meet with representatives of the Nebraska Department of Health to discuss the subject of violence in schools, possibly developing a program of cooperation between the Association and the Department. An oral report of this meeting should be available for the House at its September session.

The Committee will continue with its plans to meet with representatives of college and university programs of teacher training during the academic year, with a report at the Annual Meeting in the spring of 1995.

ADDENDUM TO THE REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

On 7 September, the chairman of the Committee met with Jim Dills, Division Director of Health Promotion, and other representatives of the Nebraska Department of Health to discuss how they and the Committee might work together to enhance health education in the schools of the state.

The Department agrees with the efforts that the Committee has made in working to improve health education. They agree that identifying a medical consultant to schools is an appropriate step in this effort. They have identified a publication from the AMA — Culturally Competent Health Care for Adolescents: A Guide for Primary Care Providers — as an aid to schools in this part of the curriculum. Since the cost of this brochure is $7.50 for AMA members, it is hardly feasible to give it general distribution, but the Committee recommends that its availability be advertised in appropriate publications of the NMA.

The Department can make available its brochure — Healthy Learners: The Key: School Nurses. The Committee recommends that copies of this might be sent to members of the NMA in one of its regular mailings.

The Department has participated in several surveys and studies of the health status of students in our schools, including studies of their risk-taking behavior.

The Committee proposes to continue a close association with the Division of Health Promotion and to continue to meet with directors of schools of education in the colleges and universities of the state.

Respectfully submitted,
Warren Bosley, M.D., Chairman

REPORT OF THE AD-HOC COMMITTEE ON HEALTH CARE INSURANCE AND MEDICAL DELIVERY SYSTEMS

Dale E. Michels, M.D., Lincoln - Chairholder; David W. Bouda, M.D., Omaha; Thomas M. Connors, M.D., Omaha; Allen D. Dvorak, M.D., Omaha; James A. Fosnaugh, M.D., Lincoln; Herbert A. Hartman, Jr., M.D., Omaha; Lawrence D. Helmick, M.D., Kearney; Bruce W. Henricks, M.D., Fremont; Jeffery B. Itkin, M.D., Omaha; Robert L. Kruger, M.D., Omaha; Scott P. Liggett, M.D., Lincoln; Blaine Y. Roffman, M.D., Omaha; H. Russell Semm, M.D., Omaha; Robert F. Shapiro, M.D., Lincoln; Rick J. Windle, M.D., Lincoln.

The Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems has met three times since the Annual Session of the House of Delegates. The charge to the Committee by the President of the NMA is as follows:

1) To exchange information between health care insurance/medical delivery system industry and the Nebraska Medical Association,

2) To serve as an arena for discussion and resolution of problems for NMA member physicians in regard to insurance/medical delivery systems,

3) To serve as a forum for review of proposals to assess feasibility and impact on NMA members by insurers/medical delivery systems, and

4) To review complaints submitted by NMA physician members and the health care insurance/medical delivery system industry.

The Committee dealt with resolutions directed to it by the Board of Directors. Included in these resolutions was "Patient Freedom of Choice" which was discussed in some detail and possible legislation addressing this resolution was also discussed. "Appropriate Medical Care Decisions Made by Insurance Companies Remote From the Patient" was reviewed and the possibility of developing technical advisory committees to assist insurers to be able to provide input in the development of performance criteria was discussed. The State of Nebraska Department of Insurance role in dealing with physicians, and physicians' role as providers contracting with insurance companies was also discussed. The Department has no part or responsibility in this at present and we have discussed the possibility of developing legislation that would give the Dept. of Insurance an oversight function in this area.

Blue Cross/Blue Shield concerns regarding the "Any Willing Provider" issue have been reviewed by the Committee and the Chair made a presentation on this issue to the Blue Cross/Blue Shield of Nebraska Board of Directors at their Orientation Session. In addition, discussions are ongoing on how the needs of the physician and the insurer can both be met, or what legislative redress may be needed for the patient to maintain "Freedom of Choice".

The Committee, through the AMA, has determined what issues from insurers must be reported to the National Practitioner Data Bank. Specific decisions by independent PPO's must be reported when they have adversely affected the clinical privileges of a physician for more than thirty days or where specific physician privileges are suspended, revoked, denied or not renewed. This would include any physician who voluntarily surrenders or restricts his or her own privileges while under investigation. This may have a significant impact on those physicians who are being subjected to close scrutiny concerning their practice patterns.

The Committee reviewed a concern expressed and issues relating to the denial of a "willing provider" who applied to take over the care of a number of "insureds" from a retiring associate, and the subsequent denial of that application. The patients were then forced to seek their care from other physicians causing potential disruption in their care.

The proposed change in the reimbursement mechanism for outpatient laboratory services required much time of the Committee and provided input from a large number of NMA members. The Committee continues to work with Blue Cross/Blue Shield of Nebraska to provide a satisfactory resolution to the problems of: 1) the time and additional effort of office based physicians to communicate laboratory reports to their patients, 2) the effort required by these physicians to provide the required coding and billing information to the laboratory if they will be required to do the billing, 3) the concerns about "unbundling" of chemistry and other profiles and the submission of multiple codes for laboratory panels of tests, 4) the negative impact for many physicians who have maintained reasonable billing for laboratory and have thus kept their costs for other services at a lower level, and 5) the use of Medicare reimbursement practices as a positive "standard" for the medical community when indeed some of their policies have been found to be lacking in logic, as well as contributing to the need for primary care physicians to find other ways to meet their overhead including cost shifting. Although the solution has not been finalized, Blue Cross/Blue Shield of Nebraska has delayed implementation of any change at the present time. Included in this discussion is the possibility of developing a "medical advisory committee" to work with insurers when these issues arise.

The Committee has reviewed decisions by insurers not to renew contracts with specific physicians and has made sure that member physicians were given opportunity to make corrections in their practice style to continue participation. In addition, the Committee has reviewed requests for information by insurance companies as a part of their "quality assurance activities", requests for large discounts by insurers for "prompt payment" and other similar issues. The committee continues to solicit input from NMA members regarding problems encountered by them in dealing with insurers or other medical delivery systems. The Committee feels that it can be of most help to NMA members if it can assist in dealing with specific, but potentially widespread, problems.

REPORT OF THE COMMITTEE ON HEALTH PLANNING

Dale E. Michels, M.D., Lincoln - Co-Chairholder; Herbert E. Reese, M.D., Lincoln - Co-Chairholder; Darroll J. Loschen, M.D., York - Board Liaison; Allen D. Dvorak, M.D., Omaha; Paul E. Collicott, M.D., Lincoln; James A. Fosnaugh, M.D., Lincoln; Suzanne H. Granger, M.D., Omaha; Patricia A. Helke, M.D., Omaha; John J. Hoesing, M.D., Omaha; Mark B. Horton, M.D., Lincoln; John F. Riedler, M.D., Omaha; Jerald R. Schenken, M.D., Omaha; Mylan R. VanNewkirk, M.D., Brule; Gregg F. Wright, M.D., Lincoln; Christopher Caudill, Omaha; Barry Bohlen, Omaha; Paul Shurnas, Omaha; Michael Tran, Omaha.

The Committee has not met since the Spring Session of the House of Delegates. With the major push in Congress for Health Care Reform, it was felt that the best possible committee action during the summer was no action other than to observe how the many proposals would fare in Washington, D.C.

The Committee has as its members several of the physicians who also serve on the Governor's Blue Ribbon Coalition to Study Health Care in Nebraska. Physicians on the Coalition include Allen Dvorak, M.D., Herb Reese, M.D., Todd Sorensen, M.D., Ron Klutman, M.D., Carol Aschenbrener, M.D., Richard O'Brien, M.D., and Harold Maurer, M.D. With the reform activity occurring in Washington and the upcoming election for governor, there has not been much activity occurring with the Coalition.

It is anticipated that the Committee on Health Planning will become more active with the evaluation of the health care concerns unique to Nebraska once we see what if anything will be provided by the Congress. If Congress fails to act, it is the opinion of the Chair that it will be even more important for our Committee to present recommendations to the Governors Coalition and to our own Commission on Legislation and Governmental Affairs to be considered as legislation to be introduced into the 1995 Unicameral.

REPORT OF CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

August, 1994

The art of progress is to preserve order amid change and to preserve change amid order.

Whitehead

This has been, as in other Academic Health Centers, a year to position ourselves in education, research and service for the evolution in progress of health care. There have been major events which have greatly enhanced our efforts toward that end.

Creighton University and American Medical International overcame a great challenge when a settlement of legal differences was negotiated out of court and a new healthcare partnership was formed. As part of this partnership, Creighton and AMI will be establishing a Physician Hospital Organization to ready our health care delivery system in order to participate in all forms of managed care contracts. Creighton's ownership more closely aligns our faculty's interests with those of Saint Joseph Hospital and the Center of Mental Health. It will enhance our education and research programs, better enable us to compete in the changing health care environment and continue providing quality care.

During the year we have completed the structure of our unified practice plan, **Creighton Medical Associates**. With the dedication of resources from the settlement with AMI we will be able to improve our primary care network and have the capability to cover in excess of 100,000 lives if managed care is the next step in the health care delivery evolution. This was accomplished through the efforts of a visionary faculty who were willing to work in a collegial fashion.

With all the questions about the future of medicine it remains for aspiring medical students to preserve order amid change. The best and the brightest continue to apply within excess of 9,000 attempting to enter the profession the past year. The MCAT and GPA's are high, commitment to service is evident and an increased number who see the wisdom of a career in primary care. Thinking of the leadership of medicine moving to these most capable hands is a most comforting feeling.

Dr. John T. Elder, professor of pharmacology, has been selected to receive the Associate of American Medical Colleges - Minority Affairs Section Service Award. The award honors those who have made outstanding contributions to minorities in medical education. Dr. Elder was recognized for his work as director of Creighton's Post-Baccalaureate Program as well as his long-standing support as a role model to minority individuals in medical education and his efforts to expand opportunities for minority young people. Since the program began in 1975, approximately 85 percent of its participants have been accepted to medical or dental school.

Recruitment is a constant activity of Academic Health Centers. Over the past year we have brought to Creighton new chairs: Dr. Peter Doris in Radiology, Dr. Stephen Chartrand in Pediatrics and Dr. J.J. McCarthy in Anesthesia.

We, for many reasons, are optimistic about the future - not because our crystal ball is any clearer than yours, however, with our new structure, our visionary leadership, our outstanding student body, we anticipate nothing but elevation of quality education, research and service as we constantly strive to the goal of excellence.

Respectfully submitted,
Thomas J. Cinque, M.D.
Dean, School of Medicine

MINUTES, BOARD OF COUNCILORS

The Board of Councilors met on September 15, 1994, at the Cornhusker Hotel, Lincoln, Nebraska.

Members present were: Doctors Roger S. Jernstrom, Paul M. Scott, Gordon D. Adams, Paul E. Plessman, Judith A. Butler, Gordon D. Bainbridge, Charles F. Damico, Milton R. Johnson, Frederick F. Paustian, David L. Bacon and Richard H. Meissner.

The meeting was called to order by the Chairman, Charles F. Damico, M.D.

Dr. Damico welcomed Doctors Judith Butler and Paul Plessman as the newly elected Councilors for the 7th and 6th Districts, respectively.

Dr. Damico called for approval of the minutes of the Annual Session as printed in the July issue of the **Nebraska Medical Journal**. The minutes were approved as written by motion made, seconded and passed.

The Councilors discussed the reports and resolutions contained in the handbook. Dr. Damico noted that due to a potential 1995 budget to income deficit, it will probably be necessary to implement a dues increase.

The Councilors were informed that the NMA's Blue Cross/Blue Shield group health insurance plan will offer a drug card with a new PPO option and that the decision as to whether to offer a drug card with the two existing coverage options would be made in January. As an aside, Dr. Damico noted that under current law, it is considered unprofessional conduct for a physician to dispense any controlled substance to himself or, except in emergency situations, to a family member. Clarification was being sought as to the definition of "emergency".

In reference to the Medicaid co-pay issue, Dr. Paustian informed the body that according to the Department of Social Services, a physician who has a uniform policy requiring co-payments can deny service to a Medicaid patient if they are unable to pay.

Dr. Meissner questioned the statement in the Department of Social Services' report that over $600,000 had been paid out for primary care procedure codes since institution of the $100 licensure assessment.

In reference to the Finances section of the Board report, it was noted that the NMA had entered into a settlement agreement with Blue Cross/Blue Shield regarding the group health insurance plan and as a result of this agreement, a sizeable amount of money had been accumulated. The Association is currently seeking legal counsel as to whether the Association can use this money or whether it needs to be channeled back to the policyholders.

Dr. Damico asked Dr. Paustian to explain the restructuring of the NMA currently being considered by the Commission on Association Affairs Working Group. He noted that due to a sense of a lack of effectiveness in the current NMA structure, a study group had been formed, comprised of Drs. Joel Johnson, Darroll Loschen, David Bacon, Robert Shapiro and himself. The following changes are being considered: (1) Restructuring the NMA into 6-8 regions, each comprised of a minimum of 100 physicians, eliminating the need for the current councilor districts; (2) Representation on the NMA Board of Directors from each region; (3) NMA Board members serving as chairholders of NMA commissions.

Clarification was sought as to the decision making capability of each region. Dr. Paustian stated that each region would be responsible for making decisions affecting their own district. Dr. Jernstrom expressed his frustration over the limited function of the Board of Councilors. It was acknowledged that the original function of the Board of Councilors has been eroded. Dr. Bacon reminded the Councilors that these ideas are only a concept and that another possibility which had been discussed by the group was to use the Councilors as the head of each region and perhaps have co-councilors in expansive regions. He noted that if the regions were developed to approximate the Department of Social Services' and Department of Health's, the physicians within each region would have more in common.

Dr. Johnson noted that part of the difficulty in recruiting new members in the Scottsbluff area is that most non-members perceive having no access to the state level. He felt that the inclusion of a representative from each proposed region on the NMA's Board of Directors would provide the necessary link. It was noted that the time frame for implementation of the restructuring would be one to two years.

Dr. Butler mentioned the possibility of holding NMA meetings in an outstate location occasionally. It was explained that this had been tried in the past with little success.

Clarification was sought on the NMA's position regarding Blue Cross/Blue Shield's Clinical Lab Policy. The policy's implementation is currently in abeyance while the NMA's Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems addresses this issue.

Dr. Damico, in reference to membership, asked each councilor to review his respective non-member listing and apprise the NMA staff of any corrections, additions, etc.

In reference to the Department of Social Services' Medicaid Managed Care Plan, it was noted that the State has until November to select a provider(s) and it will be put out to bid shortly. Dr. Meissner queried whether the RFPs have been returned and Mr. Schellpeper stated that the Governor's office has indicated the Association will be provided a draft copy on Friday morning.

The requests for Life Membership, Associate Membership and the list of 50-Year Practitioners to be recognized at the 1995 Annual Session were reviewed. Dr. Plessman sought clarification regarding Associate Membership. Mr. Schellpeper explained that a physician who has practiced for 25 years or more and is completely retired from active practice can become an Associate member. An Associate member will pay dues in the amount of 30% of the current active dues level beginning in 1995. The requests and the list were approved by the Councilors by motion made, seconded and passed.

Resolution #7, regarding nurse practitioners, generated considerable discussion. The consensus of the group was that independent practice was not desirable.

Dr. Paustian explained the difference between the terms "willing provider" and "point of service option". A "willing provider" is agreeable to participate in a managed care plan and is willing to abide by the contract terms. A "point of service option" is where a physician is willing to provide the service but is not willing to contract with the firm. It was noted that with the "point of service" option, there are usually deductibles and co-pays required which deter usage of these physicians by the policyholders.

In reference to Resolution #13, it was noted that substantial investigation is undertaken prior to any information being released to the media regarding allegations against a physician.

Following an executive session, an election for Chairman and Secretary-Treasurer was held. A motion was made, seconded and passed to re-elect Dr. Damico Chairman of the Board of Councilors. A motion was made, seconded and passed to elect Dr. Judith Butler as Secretary-Treasurer of the Board of Councilors.

There being no further business, the meeting was adjourned.

MINUTES, HOUSE OF DELEGATES

FIRST SESSION

The First Session of the House of Delegates was held September 16, 1994, at the Cornhusker Hotel, Lincoln, Nebraska.

The meeting was called to order by the Speaker, Dr. Richard Meissner. 71 Delegates were present and the meeting was declared in session. Seating of Alternate Delegates for Delegates took place.

Dr. Carl Cornelius was appointed parliamentarian and Dr. Allen Dvorak presented the invocation.

The minutes of the 1994 Annual Session were approved by motion made, seconded and passed.

Dr. Frederick Paustian, NMA President, made two presentations to Dr. Jerald Schenken of Omaha. The first presentation on behalf of the Nebraska Medical Association was in recognition of his service on the AMA Board of Trustees. He then moved that the NMA honor Dr. Schenken with the Certificate of Distinguished Service as defined in the Association's Bylaws. The motion was seconded and carried. He noted that this presentation was the first of its kind by the Association. Dr. Schenken expressed his appreciation to the House.

Reference Committee Assignments were made as follows:

REFERENCE COMMITTEE 1

- Report, Board of Directors, Item #13, Resolution 16 (A94) Nebraska Department of Social Services Manual and Co-Payment Schedule
- Report, Board of Directors, Item #15, Resolution #18 (A94) Toll Free Number for Medicare Patients' Complaints Regarding Decisions of Sunderbruch Corporation
- Report of the Nebraska Department of Social Services
- Report of Ad-Hoc Committee on Medicaid Services
- Report of the NMA PRO Overview Committee
- Resolution #3 - Greater Nebraska Caucus - Medicaid Co-Pay
- Resolution #8 - Greater Nebraska Caucus - Department of Social Services Appeals Mechanism
- Resolution #18 - C.J. Cornelius, Jr., M.D., - AIDS Treatment and Reimbursement Plan

REFERENCE COMMITTEE 2

- Report, Board of Directors, Item #1, Resolution #1 (A94) Support for Medical Service Account Format for Health System Reform
- Report, Board of Directors, Item #24, PEW Foundation Achievement Award
- Report, Board of Directors, Item #28, Congressional Contact
- Report, Board of Directors, Item #34, Rural Health Conference
- Report, Board of Directors Item #35, Strategies for Health Care Reform Project
- Report, Board of Directors, Item #39, Telecommunications and Information Planning Grant
- Report of the University of Nebraska Medical Center
- Report of the Committee on Health Planning
- Report of the Committee on Rural Health
- Report of the NMA Advisory Committee on Nursing Home Regulations
- Report of the Creighton University School of Medicine
- Life & Associate Membership Requests & 1995 50-Year Practitioners
- Resolution #7 - Lancaster County Medical Society - Nurse Practitioners
- Minutes, Board of Councilors

REFERENCE COMMITTEE 3

- Report, Board of Directors, Item #2, Resolution #2 (A94) Improvement in Reimbursement for Primary Care Services in Rural Areas
- Report, Board of Directors, Item #16, Definition of Primary Care
- Report, Board of Directors, Item #17, AMA Leadership Conference
- Report, Board of Directors, Item #22, Federation Study Consortium
- Report, Board of Directors, Item #27, Continuing Medical Education
- Report, Board of Directors, Item #36, Doctor Cornelius Selected as Alternate Delegate
- Report, Board of Directors, Item #37, Les Veskrna, M.D., Selected
- Report, Board of Directors, Item #38, AMA Strategies for Change Workshop
- Report of the Delegate to the AMA
- Report of the Delegate to the AMA Young Physicians Section
- Report of the Ad-Hoc Committee Re: Medicare
- Report of the Scientific Sessions Committee
- Resolution #2 - Greater Nebraska Caucus - AMA Leadership Conference
- Resolution #14 - Metro Omaha Medical Society - Willing Provider
- Resolution #17 - Lancaster County Medical Society - Payment Denial Explanation on Medicare Benefit Statements

REFERENCE COMMITTEE 4

- Report, Board of Directors, Item #6, Resolution #6 (A94) Dues Increase
- Report, Board of Directors, Item #8, Resolution #8 (A94) Residency House Officer NMA Representation
- Report, Board of Directors, Item #9, Resolution #11 (A94) Retired Physicians Volunteer Efforts
- Report, Board of Directors, Item #10, Resolution #12 (A94) Appropriate Medical Care Decisions
- Report, Board of Directors, Item #12, Resolution #15 (A94) NMA Group Health Insurance Carrier
- Report, Board of Directors, Item #14, Resolution #17 (A94) Physician Directed Management Service Organization
- Report, Board of Directors, Item #18, Membership
- Report, Board of Directors, Item #19, NMA Blue Cross/Blue Shield Group Health Insurance Plan
- Report, Board of Directors, Item #20, Finances
- Report, Board of Directors, Item #21, Additional Employee
- Report, Board of Directors, Item #25, Technical Advisory Committee
- Report, Board of Directors, Item #26, Practice Parameters
- Report, Board of Directors, Item #40, Nominations and Appointments
- Resolution #1 - Hall County Medical Society - Bylaws Amendment to Allow V.A. Hospital Physicians to Join Association Without Valid Nebraska License

Resolution #4 - Lancaster County Medical Society - State and County Structure
Resolution #6 - Lancaster County Medical Society - Quality Advocacy
Resolution #12 - Metro Omaha Medical Society - National Committee on Quality Assurance

REFERENCE COMMITTEE 5
Report, Board of Directors, Item #3, Resolution #3 (A94) Any Willing Provider Legislation, Resolution #10 (A94) Willing Provider and Patient Freedom of Choice, Resolution #13 (A94) Willing Providers
Report, Board of Directors, Item #7 (A94) Cost of Subpoenaed Records
Report, Board of Directors, Item #23, Community Health Services
Report, Board of Directors, Item #32, Physician Licensure/Discipline
Report, Board of Directors, Item #33, Blue Cross/Blue Shield Clinical Lab Policy
Report of the Board of Examiners in Medicine & Surgery
Report of the State Department of Health
Report of the Commission on Legislation & Governmental Affairs
Report of the NMA Radiation Safety Working Group
Report of the Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems
Resolution #5 - Lancaster County Medical Society - Patient Protection Act
Resolution #9 - Metro Omaha Medical Society - Patient Freedom of Choice
Resolution #10 - Metro Omaha Medical Society - Patient Protection Act
Resolution #11 - Metro Omaha Medical Society - Quality Assurance
Resolution #13 - Metro Omaha Medical Society - Confidentiality of Review
Resolution #15 - Cheyenne-Kimball-Deuel County Medical Society - Limited X-Ray System Operator Edict

REFERENCE COMMITTEE 6
Report, Board of Directors, Item #4, Resolution #4 (A94) Breast Cancer Education
Report, Board of Directors, Item #5, Resolution #5 (A94) Physician Education, Breast Cancer
Report, Board of Directors, Item #11, Resolution #14 (A94) Prohibition of Smoking in Public Places
Report, Board of Directors, Item #29, Preventive Law Seminar
Report, Board of Directors, Item #30, Health Quest
Report, Board of Directors, Item #31, "Every Woman Matters" Project
Report of the Ad-Hoc Committee on Health Education
Report of the Ad-Hoc Committee on Low Level Radioactive Waste Disposal
Report of the Ad-Hoc Committee on Maternal & Child Health
Report of the Commission on Public Affairs
Resolution #16 - Greater Nebraska Caucus - NMA Endorsement of the Commission on Office Laboratory Accreditation (COLA)

Dr. Zweiback, on behalf of the Metro Omaha Medical Society, withdrew Resolution #13 as the process in question had been clarified.

Dr. Paustian addressed the House regarding the concept of restructuring the NMA being developed by the Commission on Association Affairs Working Group. He noted that due to a perceived lack of effectiveness of the current NMA structure, the following changes were being considered: (1) Restructuring the NMA into 6-8 regions, each comprised of a minimum of 100 physicians, eliminating the need for the current 12 councilor districts; (2) Representation on the NMA Board of Directors from each region; and (3) NMA Board members serve as chairholders of NMA commissions in order to improve communication. He appealed to the delegates to consider the impact of these changes and provide comments to the Working Group. Dr. Cornelius queried whether this concept could be reprinted and distributed to the membership. Dr. Paustian informed him that a future "President's Page" in the **Nebraska Medical Journal** would address this issue.

Dr. Loschen briefly addressed the House, informing the delegates of the formation of a Nebraska Medical Directors Association and urging those interested in membership to contact the NMA office.

Dr. Ronald Klutman informed the House that Mr. Grey Borden of the Nebraska Department of Health would be at Reference Committee #5 to explain the current status of the state immunization program and to answer any questions regarding the program.

Following an Executive Session, Dr. Meissner stated that Reference Committees 1, 2 & 4 would meet immediately following recess of the House and Reference Committees 3, 5 & 6 would meet an hour and 15 minutes later. He also reviewed the room assignments for the reference committees.

There being no further business, the House recessed until 8:30 a.m. Saturday morning.

HOUSE OF DELEGATES

SECOND SESSION

The Second Session of the House of Delegates was held September 17, 1994. The meeting was called to order by the Vice Speaker, Doctor David Little. 69 delegates were present and the meeting was declared in session. Seating of Alternate Delegates for Delegates took place.

Dr. Little called for approval of the minutes of the First Session, and these were approved as printed.

Reports of the Reference Committees were presented as follows:

Reference Committee #1

Reference Committee #1 considered 5 reports and 3 resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #13, RESOLUTION #16 (A94) NEBRASKA DEPARTMENT OF SOCIAL SERVICES MANUAL AND CO-PAYMENT SCHEDULE

The Board's report was straight forward and little discussion was generated.

RECOMMENDATION:

1. Your reference committee recommends the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(2) REPORT OF BOARD OF DIRECTORS, ITEM #15, RESOLUTION #18 (A94) TOLL FREE NUMBER FOR MEDICARE PATIENTS' COMPLAINTS REGARDING DECISIONS OF SUNDERBRUCH CORPORATION

A lively discussion ensued regarding the efficacy of the toll free number. The reference committee disagreed with the Board's impression that the usage would not justify the cost. It was felt than an 800 number could be used to compile not only Medicare patients' complaints regarding decisions of the Sunderbruch Corporation, but that multiple usage including Medicare and managed care complaints could be assimilated through an NMA 800 number. Member physicians could also use this to communicate with the leadership.

RECOMMENDATION:

1. Your reference committee recommends the NMA establish an 800 number to field comments on all the above issues.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Considerable discussion ensued. Dr. Paustian informed the House that the Board of Directors had conducted a survey of state medical associations regarding the provision of an 800 number. He noted that the costs incurred by the states having a dedicated 800 line varied from $120 per month in North Dakota to $2,550 per month in Pennsylvania. He also indicated it would be necessary to hire an additional staff person who would have the knowledge and ability necessary to process, investigate or refer complaints. The estimated personnel cost could be $25,000 - $30,000 per year. In addition, he stated that according to Joe Connolly of the Sunderbruch Corporation and a California Medical Society spokesperson, the vast majority of complaints fielded would probably be from malcontents rather than be complaints of substance. He explained that it was due to these concerns that the Board felt it most prudent not to pursue installation of an 800 number.

Dr. Dale Michels, a member of the reference committee, voiced his support for the recommendation, stating than an 800 number would enhance communication with the Association's membership. Dr. James Fosnaugh rose in opposition, questioning the source of the funding to pay for this in light of the fact that the Board was already proposing a dues increase. His concerns were echoed by Dr. John Reed.

Dr. Zweiback defended the reference committee's recommendation and stated that the funding necessary to support such a service could be generated from an increase in membership. He suggested that the 800 number be established for a period of time, after which the Board and House could review its true financial impact upon the Association. Dr. Darroll Loschen stated that the cost of calls which he placed to the Association office had never served as a deterrent. Dr. Paustian cited the average costs per month for three states contiguous to Nebraska: Iowa - $780; Kansas - $600 and Missouri - $375. He estimated that $10-15 of each members' dues would go toward operation of the 800 number.

Dr. Little called for a hand vote. The reference committee's recommendation was defeated by a vote of 22 to 26.

(3) REPORT OF THE NEBRASKA DEPARTMENT OF SOCIAL SERVICES

An animated discussion was led by Mary Dean Harvey and multiple members of her able staff. They stressed that the Nebraska Department of Social Services' primary concern is access, quality and outcome and your reference committee concurred. The Department reported that the "M.D. tax" was underspent last year and the excess would be returned to the primary care physicians in this year's allocation.

RECOMMENDATION:

1. Your reference committee recommends the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(4) REPORT OF THE AD-HOC COMMITTEE ON MEDICAID SERVICES

The chairholder of the Ad-Hoc Committee on Medicaid Services, Doctor Chris Caudill, fielded numerous questions in an informative fashion.

RECOMMENDATION:

1. Your reference committee recommends the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(5) REPORT OF THE NMA PRO OVERVIEW COMMITTEE

An interesting discussion regarding treatment guidelines and practice parameters was led by Doctor Herb Hartman, Chairholder of the Overview Committee.

RECOMMENDATION:

1. Your reference committee recommends the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(6) RESOLUTION #3 - GREATER NEBRASKA CAUCUS - MEDICAID CO-PAY

Resolution #3 read as follows:

WHEREAS, the Nebraska Legislature has enacted LB 808, which mandates the collection of co-pay from Medicaid beneficiaries at the "point of service", and

WHEREAS, the implementation of this legislation has resulted in a significant procedural and financial hardship to all providers of services to Medicaid beneficiaries, and

WHEREAS, there is every indication that continuation of this onerous policy will result in a significant decrease in the numbers of physicians willing to care for Medicaid beneficiaries, and thus further compromise access to care for these individuals, and

WHEREAS, the savings realized by the Medicaid program from this legislation is far less than projected,

THEREFORE, BE IT RESOLVED, that the NMA, through appropriate commissions and committees, lobby for repeal of this legislation.

There was much discussion in support of this resolution. The Department of Social Services noted the amount of savings realized by this legislation and it was indeed far less than projected. It was also pointed out, however, that all of the managed care programs being contemplated would make this a moot point since co-pay will disappear under managed care. Therefore, this was not thought to be a high priority item.

RECOMMENDATION:

1. Your reference committee recommends that Resolution #3 be adopted. The committee also recognized that this was a short-term solution and would not recommend the expenditure of tremendous assets to repeal this legislation.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Klutman referred to an article in Saturday's Omaha World Herald which referred to the co-pay issue and appealed to the House leadership to keep reporters apprised of any developments or circumstances having a bearing on an issue. Dr. Zweiback informed the House that reporters are given a copy of the Delegates' handbook in advance of each Annual and Fall Session. Dr. Caudill attempted to clarify the issue, noting that the Department of Social Services had stated that once managed care is in place, the co-payment may no longer exist. It was noted that if it is the routine business practice of the physician to refuse service to any individual with uncollected debt, the physician may include uncollected copayments under this practice, and that providers of care must give sufficient notice to the client before services can be denied. Dr. Meissner interjected that it would be necessary for the physician to see the Medicaid patient at least once without receiving the co-payment before service could be denied, otherwise there is the possibility that no debt could exist. Following this discussion, the House adopted this section of the report.

(7) RESOLUTION #8 - GREATER NEBRASKA CAUCUS - DEPARTMENT OF SOCIAL SERVICES APPEALS MECHANISM

Resolution #8 read as follows:

WHEREAS, the Department of Social Services has contracted with the Sunderbruch Corporation to do precertification and utilization review, and

WHEREAS, the determination of medical necessity is based on clinical judgement, and

WHEREAS, the current appeals mechanism regarding denials is carried out by an attorney in the employ of the Department of Social Services and not by persons with a medical background.

THEREFORE, BE IT RESOLVED, that the NMA study this mechanism and in consultation with the Department of Social Services develop a more acceptable mechanism for the adjudication of appeals utilizing contract physicians rather than employed attorneys for this process.

Much heated discussion ensued regarding medical judgements apparently made by non-medical people. It became clear that the primary problem was one of communication. Physicians do not understand the process of determination and reconsideration of appeals.

RECOMMENDATION:

1. Reference Committee #1 recommends that the Nebraska Medical Association, the Sunderbruch Corporation, and the Department of Social Services work to develop a better method of communication with physicians regarding the mechanism of review of medical necessity and the process of reconsideration and appeals.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(8) RESOLUTION #18 - C.J. CORNELIUS, M.D. - AIDS TREATMENT AND REIMBURSEMENT PLAN

Resolution #18 read as follows:

WHEREAS, the number of persons with AIDS requiring hospital treatment is increasing in Nebraska, and

WHEREAS, the cost of AIDS treatment is significantly higher than the cost of other community acquired infectious diseases, and

WHEREAS, many of these infected persons are covered by the Department of Social Services which pays for hospital treatment on a per diem basis which results in cost shifting to the private payors, and

WHEREAS, small hospitals are not fully capable of caring for these infected persons because of staffing, physical plant and training of personnel problems and could face financial disaster if forced to care for several cases with resistant complicating conditions such as Tuberculosis;

THEREFORE, BE IT RESOLVED, that the NMA consult with the State Health Department and the Department of Social Services regarding the advisability of developing a network of treatment centers for caring for AIDS patients and provide for adequate reimbursement rather than the current per diem rates.

There was general agreement with the adverse impact AIDS patients could have on small institutions. A state-wide network of treatment centers could be utilized to enhance treatment and more fairly distribute costs.

RECOMMENDATION:

1. Your reference committee recommends that the NMA consult with the Department of Health and Department of Social Services regarding the advisability of developing regional treatment centers to care for AIDS patients and provide adequate reimbursement rather than the current per diem rates.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #1 AS A WHOLE. I gratefully acknowledge the assistance and wisdom of Doctor Dale E. Michels and Doctor Gordon Bainbridge. This was seconded and carried.

Respectfully submitted,
Eugene M. Zweiback, M.D., Chm., Omaha
Gordon D. Bainbridge, M.D., Grand Island
Dale E. Michels, M.D., Lincoln

Reference Committee #2

Reference Committee #2 considered 11 reports, 1 resolution, the minutes of the Board of Councilors and the Requests for Life and Associate Membership and the list of the 1995 50-Year Practitioners. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #1, RESOLUTION #1 (A94) SUPPORT FOR MEDICAL SERVICE ACCOUNT FORMAT FOR HEALTH SYSTEM REFORM

This NMA resolution was successful at the June 1994 AMA meeting as outlined in this report. Testimony at the Reference Committee expressed opposition to employer mandates to pay for health insurance. It was observed that the NMA House of Delegates has already adopted policy opposing employer mandates.

RECOMMENDATION:

1. That this report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(2) REPORT OF THE BOARD OF DIRECTORS, ITEM #24, PEW FOUNDATION ACHIEVEMENT AWARD

Further testimony at the committee indicated the University of Nebraska Medical Center was not selected for the PEW Foundation Achievement Award this year.

RECOMMENDATION:

1. That this report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(3) REPORT OF THE BOARD OF DIRECTORS, ITEM #28, CONGRESSIONAL CONTACT; ITEM #34, RURAL HEALTH CONFERENCE; ITEM #35, STRATEGIES FOR HEALTH CARE REFORM PROJECT; AND ITEM #39, TELECOMMUNICATIONS AND INFORMATION PLANNING GRANT; AS WELL AS THE REPORTS OF THE UNIVERSITY OF NEBRASKA MEDICAL CENTER AND CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

These reports were received without comment.

RECOMMENDATION:

1. That these reports be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(4) REPORT OF THE COMMITTEE ON HEALTH PLANNING

Dr. Herb Reese, Co-Chair of the Committee, was present to testify and answer questions for the Committee. It was observed that, as it appears system reform changes at the national level are now less imminent, the focus of the NMA may need to shift to more assertive action at the state level. Please note the written opinion of the Committee Chair that we need to be actively considering recommendations to introduce legislation into the 1995 Nebraska Unicameral, which convenes in less than 4 months from now.

RECOMMENDATION:

1. That this report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius sought clarification as to the legislation the Chairholder of the Committee on Health Planning proposed. Dr. Fosnaugh stated that the report had not been specific in this regard. Dr. Cornelius pressed for clarification. Dr. Dale Michels, Chairholder of the Committee on Health Planning, explained that due to the lack of movement by the Governor's Blue Ribbon Coalition in the area of health system reform, he felt it imperative that the Association propose health system reform changes. He noted that nothing had been committed to at this point in time and welcomed input from the House and the membership in the development of any such legislation. The House then adopted this section of the report.

(5) REPORT OF THE COMMITTEE ON RURAL HEALTH AND RESOLUTION #7 - LANCASTER COUNTY MEDICAL SOCIETY - NURSE PRACTITIONERS

Resolution #7 read as follows:

WHEREAS, the Nebraska Medical Association (NMA) has long recognized and valued the contributions made to health care delivery in Nebraska by nurse practitioners, and

WHEREAS, the NMA endorses their participation under the responsible supervision of fully licensed physicians, and

WHEREAS, the extension of physician care by mid-level practitioners promotes access to health care;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association implement educational efforts to alert physicians to the significant benefit their patients might realize through the incorporation of mid-level practitioners, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association continue to work together with nurse practitioners to avoid further polarization.

This report and resolution were discussed together and at length. Strong support for this report and for this resolution was expressed. Several testifiers emphasized safety and quality issues and wish the NMA to affirm its opposition to independent practice by nurse practitioners. The Chair of the Scientific Sessions Committee indicated that part of the annual educational session in April will be devoted to this issue and welcomes input from the membership. The committee also wishes to emphasize that the Nebraska Medical Directors Association is for any physician with strong interest in nursing home care issues, so the name is a bit of a misnomer. Any physician with concerns about these issues is encouraged to join this new association. Membership is $25 per year.

RECOMMENDATIONS:

1. That the Report of the Committee on Rural Health be filed.

2. Than an additional resolved be appended to Resolution #7, so that the resolution would now read as follows:

> "THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association implement educational efforts to alert physicians to the significant benefits their patients might realize through the incorporation of mid-level practitioners, and
>
> BE IT FURTHER RESOLVED, that the Nebraska Medical Association continue to work together with nurse practitioners to avoid further polarization, and
>
> BE IT FURTHER RESOLVED, that the NMA affirm its position that nurse practitioners should continue to participate under the responsible supervision of fully licensed physicians as currently structured."

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(6) REPORT OF THE NMA ADVISORY COMMITTEE ON NURSING HOME REGULATIONS

The Reference Committee wishes to commend the efforts of this advisory committee, which has been sunsetted, and much of whose functions has now been assumed by the newly formed Nebraska Medical Directors Association.

RECOMMENDATION:

1. That this report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(7) LIFE & ASSOCIATE MEMBERSHIP REQUESTS & 1995 50-YEAR PRACTITIONERS

REQUESTS FOR LIFE MEMBERSHIP

METROPOLITAN OMAHA MEDICAL SOCIETY
John F. Heffron, M.D., Omaha

REQUESTS FOR ASSOCIATE MEMBERSHIP

METROPOLITAN OMAHA MEDICAL SOCIETY
Richard A. Bolamperti, M.D., Omaha
Gordon E. Fredrickson, M.D., Omaha
John L. Gordon, M.D., Omaha

LANCASTER COUNTY MEDICAL SOCIETY
Gerald N. Siedband, M.D., Lincoln

FIFTY YEAR PRACTITIONERS 1995 ANNUAL SESSION

ADAMS COUNTY MEDICAL SOCIETY
Gerald A. Kuehn, M.D., Hastings

JEFFERSON COUNTY MEDICAL SOCIETY
William P. Yoachim, M.D., Fairbury

LANCASTER COUNTY MEDICAL SOCIETY
L. Dwight Cherry, M.D., Lincoln
Kenneth J. Fijan, M.D., Tucson, AZ
G. William LeWorthy, M.D., Lincoln
Hobart E. Wallace, M.D., Lincoln

METROPOLITAN OMAHA MEDICAL SOCIETY
Louise F. Eaton, M.D., Omaha
Ray O. Gillies, Jr., M.D., Omaha
William E. Graham, M.D., Omaha
Lee B. Grant, M.D., Bellevue
Paul E. Hodgson, M.D., Omaha
Delbert D. Neis, M.D., Omaha
Anthony Ross Pantano, M.D., Omaha
Won T. Sohn, M.D.. Omaha
Richard B. Wilson, M.D., Omaha

SEWARD COUNTY MEDICAL SOCIETY
Robert W. Herpolsheimer, M.D., Staplehurst

LINCOLN COUNTY MEDICAL SOCIETY
Russell A. DeVol, M.D., North Platte

These requests were received without addition or correction. Comment was made that nominations for these membership categories must come from the local societies according to the Bylaws of the Nebraska Medical Association. In the case of some local societies which have been inactive for some time, there have been members who may have gone unrecognized for these categories. Members of the Board of Directors present at the committee indicated that this apparent deficiency will be studied and corrected with appropriate action by the Board.

RECOMMENDATION:

1. That this section of our report be filed and that the Board of Directors report back to the House of Delegates at the Annual meeting in April, 1995 regarding action on the above deficiency.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(8) MINUTES OF THE BOARD OF COUNCILORS

Several items of this document were reviewed by the Reference Committee, much of which blended in with other reports and resolutions previously discussed. Special emphasis was requested regarding the clinical lab policy of Blue Cross/Blue Shield as mentioned in the minutes of the Board of Councilors. It was emphasized that the NMA has important concerns about the implementation of this policy, and that the Board of Directors will continue to monitor this closely and continue to voice its concerns to Blue Cross/Blue Shield.

RECOMMENDATION:

1. That the minutes of the Board of Councilors be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2 AS A WHOLE. This was adopted by the House.

I thank Drs. Raymond and Johnson for serving on the committee and the committee expresses its appreciation to those who came to testify and contribute to these deliberations.

Respectfully submitted,
James A. Fosnaugh, M.D., Chm., Lincoln
Richard A. Raymond, M.D., Omaha
Milton R. Johnson, M.D., Scottsbluff

Reference Committee #3

Reference Committee #3 considered 12 reports and 3 resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #2, RESOLUTION #2 (A94) IMPROVEMENT IN REIMBURSEMENT FOR PRIMARY CARE SERVICES IN RURAL AREAS

Doctor Collicott testified he had written via the Ad-Hoc Committee on Medicare to the congressional delegation and the HCFA expressing the concerns as indicated in the resolution. He pointed out that HCFA is bound to budget neutrality by law, and cannot change conversion factors, and therefore relative value units get changed and that this may have a negative impact on the reimbursement from other carriers who copy the HCFA procedures.

RECOMMENDATION:

1. That this report be filed with compliments to Doctor Collicott for his tireless work on our behalf.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(2) REPORT OF THE BOARD OF DIRECTORS, ITEM #16, DEFINITION OF PRIMARY CARE

A substantial amount of testimony was heard regarding this definition. The definition as published and as amended by the NMA is as follows: The NMA policy states that primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive, and coordinated by a physician (M.D./D.O.) over time. Care may be provided to an age specific or gender specific group of patients as long as the care of the individual meets the above criteria.

Substantial testimony was heard that numerous other professionals have a desire to be included in the definition of primary care and for this reason, NMA had inserted the M.D./D.O. following the word "physician".

RECOMMENDATION:

1. The reference committee recommends that this definition be adopted as published.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(3) REPORT OF THE BOARD OF DIRECTORS, ITEM #17, AMA LEADERSHIP CONFERENCE & RESOLUTION #2 - GREATER NEBRASKA CAUCUS - AMA LEADERSHIP CONFERENCE

Resolution #2 read as follows:

WHEREAS, the AMA Board of Directors has recently changed both the venue and content of the Annual Leadership Conference, and

WHEREAS, these changes negatively impact the ability of the NMA to participate in these conferences, and

WHEREAS, the timing of the conference conflicts with the NMA's Annual Session of the House of Delegates, and

WHEREAS, the benefits of holding this conference in Washington, D.C., in perpetuity are outstripped by the costs and other negative consequences, and

WHEREAS, combining the proposed lobbying activities of AMA members with the leadership development activities negatively impacts both activities;

THEREFORE, BE IT RESOLVED, that the NMA delegates to the AMA propose to the AMA House of Delegates that the previous format of the Leadership Conference, as well as the previous method of selecting a venue for such conference be resumed.

Testimony was heard regarding the AMA Leadership Conference having been placed in Washington, D.C. and at a time in the spring which will conflict with our Annual Session. Testimony was heard that having the Leadership Conference in Washington may not actually be politically helpful and in fact, may dilute the effect of the Conference because it is not primarily a political conference but is a conference to discuss and inform leaders and potential leaders of issues. After hearing the testimony, the resolution was considered and it was recommended that the resolution be adopted as presented.

RECOMMENDATIONS:

1. That Resolution #2 be adopted.

2. That Item 17 in the report of the Board of Directors be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(4) REPORT OF THE BOARD OF DIRECTORS, ITEM #22, FEDERATION STUDY CONSORTIUM

Testimony was heard regarding the purpose of this study and it was felt that this study should go forward.

RECOMMENDATION:

1. That this item in the Board report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(5) REPORT OF THE BOARD OF DIRECTORS, ITEM #27, CONTINUING MEDICAL EDUCATION & REPORT OF THE SCIENTIFIC SESSIONS COMMITTEE

Testimony was heard regarding the suggested provision of socioeconomic programs through the Scientific Sessions Committee to local medical societies and to inform physicians of programs that are available. The chairholder of the Scientific Sessions Committee then discussed the scientific sessions which occur at the annual meetings and indicated that there is difficulty in finding programs which have a broad, general appeal. Several suggestions were made by participants in the reference committee.

RECOMMENDATION:

1. That these reports be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(6) REPORT OF THE BOARD OF DIRECTORS, ITEM #36, DR. CORNELIUS SELECTED AS ALTERNATE DELEGATE & REPORT OF THE BOARD OF DIRECTORS, ITEM #37, LES VESKRNA, M.D., SELECTED

The Committee considered these two items together. Doctor Cornelius had been selected as an alternate delegate because of commitments in Wisconsin. Doctor Veskrna had been selected as the alternate delegate to the June, 1994 AMA Young Physician Section Meeting.

RECOMMENDATION:

1. That these reports be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(7) REPORT OF THE BOARD OF DIRECTORS, ITEM #38, AMA STRATEGIES FOR CHANGE WORKSHOP

No testimony was heard in regard to this workshop.

RECOMMENDATION:

1. That the item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(8) REPORT OF THE DELEGATE TO THE AMA

The report was reviewed. There was discussion about the concept of preservation of the physician's right to balance bill and agreement with the AMA position.

Doctor Schenken's services were again recognized and the committee wishes to reinforce the recognition which has been given to Doctor Schenken for his long, outstanding services as an AMA Trustee.

RECOMMENDATION:

1. That the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was adopted by the House.

(9) REPORT OF THE DELEGATE TO THE AMA YOUNG PHYSICIANS SECTION

The report was reviewed. No testimony was heard in regard to the items presented.

RECOMMENDATION:

1. That the report be filed

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(10) REPORT OF THE AD-HOC COMMITTEE RE: MEDICARE

Considerable testimony was heard from Doctor Collicott and Doctor Hartman regarding the CPT codes and the restructuring of CPT codes. It was pointed out that there is a budget neutral provision in the Medicare law and that as new CPT codes are introduced, there may be a continued reduction of payment per procedure. It was also pointed out that under coding is common among the Nebraska physicians. The problem of Medicare patients' access to care was discussed and it was suggested that any problems which develop regarding access to care should be reported to the Ad-Hoc Committee on Medicare or to the councilor in the involved district.

RECOMMENDATION:

1. That the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(11) RESOLUTION #14 - METRO OMAHA MEDICAL SOCIETY - WILLING PROVIDER

Resolution #14 read as follows:

WHEREAS, the NMA has taken the position to support "any-willing-provider" legislation for the state of Nebraska, and

WHEREAS, attempts on the part of the NMA to lobby for this legislation are hindered by the insurance industry's data which suggests it will significantly raise insurance premiums, and

WHEREAS, it is our belief that the financial impact isn't as great as the insurance companies allege and

that no "objective" cost data is currently available to counter their suppositions, and

WHEREAS, no data exists on the impact that redundancy of care, duplicity of testing, and delayed initiation of treatment will have on the cost and quality of care provided in a system in which patients would be expected to regularly change physicians;

THEREFORE, BE IT RESOLVED, that the NMA forward a resolution to the AMA HOD I-94 session directing their Center of Health Policy Research to investigate the true fiscal impact of "any-willing-provider" legislation and the consequences of the loss of continuity in the physician/patient relationship.

Testimony was heard that we need to continue to insist that insurance company data be stringently analyzed. We need objective data in order to be able to counter insurance company efforts. Substantial discussion was had regarding the resolution, and because the term willing provider has met with resistance where it has been proposed, the committee recommended a change in the resolution as follows. In the first "WHEREAS", to substitute the words "patient freedom of choice of M.D./D.O. provider" for "any willing provider." In the fourth "WHEREAS", to substitute the word "duplication" for "duplicity" and in the "THEREFORE, BE IT RESOLVED" to substitute "patient freedom of choice of M.D./D.O. provider" for "any willing provider."

RECOMMENDATION:

1. That the amended resolution be adopted as follows:

> WHEREAS, the NMA has taken the position to support patient freedom of choice of M.D./D.O. ~~provider~~ legislation for the state of Nebraska, and
>
> WHEREAS, attempts on the part of the NMA to lobby for this legislation are hindered by the insurance industry's data which suggests it will significantly raise insurance premiums, and
>
> WHEREAS, it is our belief that the financial impact isn't as great as the insurance companies allege and that no "objective" cost data is currently available to counter their suppositions, and
>
> WHEREAS, no data exists on the impact that redundancy of care, duplication of testing, and delayed initiation of treatment will have on the cost and quality of care provided in a system in which patients would be expected to regularly change physicians;
>
> THEREFORE, BE IT RESOLVED, that the NMA forward a resolution to the AMA HOD I-94 session directing their Center for Health Policy Research to investigate the true fiscal impact of patient freedom of choice of M.D./D.O. ~~provider~~ legislation and the consequences of the loss of continuity in the physician/patient relationship.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. George Voigtlander suggested that the term "provider" in the amended resolution be omitted as it makes medicine sound like a franchise. Dr. Adams agreed with this suggestion. The House then adopted this section of the report as amended.

(12) RESOLUTION #17 - LANCASTER COUNTY MEDICAL SOCIETY - PAYMENT DENIAL EXPLANATION ON MEDICARE BENEFIT STATEMENTS

Resolution #17 read as follows:

WHEREAS, HCFA'S explanation of denied payments of Medicare medical services continue to cause problems with providers and patients, and

WHEREAS, the HCFA explanation of required medical services on the Medicare benefit statements is misleading and confusing when payments are denied, and

WHEREAS, the current wording on Medicare benefit statements -" . . . this service may not have been medically necessary . . ." would be clarified by the following change in wording to ". . . while the care may be necessary, it is not covered by Medicare . . . or is beyond the scope of Medicare coverage, albeit", and

WHEREAS, this suggestion has been made to the Medicare Carriers in Nebraska, Iowa and Mississippi by the Medicare Advisory Committees in those respective states;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association and the American Medical Association lend its support in the efforts to petition HCFA to change the wording as suggested.

The resolution was reviewed and felt to be excellent in achieving a less controversial impact in wording.

RECOMMENDATION:

1. That the word "albeit" be stricken from the third 'WHEREAS".

2. That the resolution be adopted a amended.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #3 AS A WHOLE. I wish to thank Doctors Louis Gogela, Jr. and Kevin Nohner for their work on this committee. Dr. Cornelius, in reference to Item 6 regarding his selection as Alternate Delegate, informed the House that the Board had exercised its fiscal responsibility and had submitted his expenses to the Wisconsin Medical Society for payment. The House then adopted the report of Reference Committee #3 as a whole.

Respectfully submitted,
Gordon D. Adams, M.D., Chm., Norfolk
Louis J. Gogela, Jr., M.D., Lincoln
Kevin D. Nohner, M.D., Omaha

Dr. Meissner assumed the podium.

Reference Committee #4

Reference Committee #4 considered 13 reports and 4 resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #6, RESOLUTION #6 (A94) DUES INCREASE

This resolution directed that the Association only implement dues increases after carefully examining finances with the House of Delegates determining that a dues increase is warranted. The Board carefully evaluates the need for dues increases in order to meet the operating expenses. This is a reaffirmation of the existing approach to determining dues for the NMA membership.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(2) REPORT OF THE BOARD OF DIRECTORS, ITEM #8, RESOLUTION #8 (A94) RESIDENCY HOUSE OFFICER NMA REPRESENTATION

This resolution directed that if an unaffiliated residency program has 100% membership in the NMA, that they be allowed one house officer seat in the NMA House of Delegates. This resolution was adopted by the House of Delegates at A94 and was referred to the Commission on Association Affairs who presents the following bylaw amendment for approval by the House of Delegates.

> Chapter VI, Section 7. A minimum of four delegates representing the House Officer staff association shall be entitled to hold voting membership in the House of Delegates. No less than two of these delegates shall be elected from the Creighton University House Staff Association and no less than two of these delegates shall be elected from the House Officers Association of the University Medical Center. Provided further that if the membership of either house staff association exceeds 50 members, then such association shall be entitled to one additional delegate for each 50 members or major fraction (50%) thereof. Such individuals must be current dues-paying members. In addition, if an unaffiliated residency program has 100% membership in the Nebraska Medical Association, it will be provided one house officer seat in the House of Delegates. House officer members shall not be considered members of a component county medical society for the purpose of determining the number of delegates to which a component county medical society is entitled.

RECOMMENDATION:

1. That the Commission on Association Affairs bylaw amendment for unaffiliated residency program representation in the House of Delegates be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report

(3) REPORT OF THE BOARD OF DIRECTORS, ITEM #9, RESOLUTION #11 (A94) RETIRED PHYSICIANS VOLUNTEER EFFORTS

The House referred this resolution to the Board which called on the Association to complete negotiations with the St. Paul Company to allow retired physicians to purchase professional liability insurance coverage at a reduced rate in order to volunteer and provide services in homeless shelters. The St. Paul Company's filing with the Department of Insurance was approved and the coverage is now available (premium approximately $100 per year). The Medical Liability Mutual is apparently developing a similar product. The Medical Protective Company has been informed of the Department of Insurance action and is currently studying the possible provision of similar coverage.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(4) REPORT OF THE BOARD OF DIRECTORS, ITEM #10, RESOLUTION #12 (A94) APPROPRIATE MEDICAL CARE DECISIONS

This resolution was adopted by the House of Delegates at A94. It called on the Association to investigate the practice of insurance companies making medical decisions remote from patients and directed the Association encourage insurance companies to refer to care they chose not to reimburse as cost/benefit based instead of care which is inappropriate. This resolution was referred and is currently being considered by the NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(5) REPORT OF THE BOARD OF DIRECTORS, ITEM #12, RESOLUTION #15 (A94) NMA GROUP HEALTH INSURANCE CARRIER

This resolution directed that the Association Board of Directors, in its annual review of the group health insurance contract, keep provider insurer relationship concerns in mind and instructed that the NMA President appoint a committee to work with third-party payors on those concerns of mutual interest that adversely impact patient/physician relationships. This resolution was referred to the newly-appointed NMA Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems for consideration, and matters of concern were presented to the NMA group health insurance carrier when the renewal for the next policy year was considered.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

6) REPORT OF THE BOARD OF DIRECTORS, ITEM #14, RESOLUTION #17 (A94) PHYSICIAN DIRECTED MANAGEMENT SERVICE ORGANIZATION

This resolution empowered the Board of Directors to proceed expeditiously to study the value and benefit of establishing a medical service organization either directly or indirectly and that the Board report back to this session of the House of Delegates on its findings. The President of the Association contacted each NMA councilor and requested information on existing or planned physician organizations of any category within their district. A meeting of physicians directly involved in these activities will be scheduled in the near future. The Board will continue to address this matter and inform the House of information that it accumulates.

RECOMMENDATION:

1. This item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(7) REPORT OF THE BOARD OF DIRECTORS, ITEM #18, MEMBERSHIP

The Board of Directors and the county medical societies continually strive to increase total membership. So far in 1994, the Association has gained 99 new members and reinstated 5 former members. There are currently 1,606 dues-paying members of the Association and 271 life and associate members. Our total membership is 1,878 which comprises 64.2% of Nebraska's 2,924 physicians.

There was discussion regarding enhancement of recruiting efforts. It was suggested that house staff recruitment be targeted. The suggestion was made that practice management, socioeconomic and legal seminars may be an enhancement for house staff membership.

RECOMMENDATION:

1. This item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(8) REPORT OF THE BOARD OF DIRECTORS, ITEM #19, NMA BLUE CROSS/BLUE SHIELD GROUP HEALTH INSURANCE PLAN

The Board is pleased to report that the NMA endorsed Blue Cross/Blue Shield health insurance plan has experienced a highly-successful financial year and there will be no rate increase for the next policy year which begins on October 1, 1994. An enhanced drug benefit could increase premiums slightly and this should be evaluated by each participant when made available in early 1995. The Board has also approved the addition of a PPO Nebraska coverage option to the package of coverage currently available under the NMA plan.

Because there has been an accumulation of excess premiums over disbursements during the past resulting in an excess of approximately $439,000 in the NMA Blue Cross/Blue Shield plan, it is anticipated that there may be a one-month "premium holiday" during 1995 should the settlement amount hold through the current policy year ending September 30, 1994.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(9) REPORT OF THE BOARD OF DIRECTORS, ITEM #29, FINANCES

The NMA 1994 budget is $718,473, This reflected a 5.4% increase over the 1993 budget. The Board spends a considerable amount of its time monitoring and analyzing the Association's financial status, relating both to the categories of income and to the expenditures necessary to operate our Association. The Board anticipates that the Association will have an estimated cash balance on December 31, 1994 of approximately $46,200. When projecting the income and expense figures for 1995, it is anticipated that there could be a deficit of approximately $50,000 by December 31, 1995. In order to address this situation, the Board will continue to closely monitor the expenditures of the Association to determine that all dollars are expended in the most efficient manner possible. A parallel approach is to increase the number of dues-paying members. Non-dues income sources such as products and services endorsed by the Association, namely the Blue Cross/Blue Shield group health insurance plan, the Bartling and Hinkle collection service, and the NMA Visa gold card, provide revenue to the NMA.

The policy of the Association has been to only request a dues increase when it is absolutely necessary. The Association's dues were increased by $25 for the 1993 membership year, and they remained the same at $360 for 1994.

Testimony was received regarding enhancing efforts to increase the membership. The importance of identifying the advantages of membership in the NMA to prospective members was discussed. The development of additional non-dues sources of revenue including the producing of seminars on socio-economic issues was suggested.

The NMA Board proposes a $30 per member dues increase effective January 1, 1995. The testimony regarding the dues increase appeared to be in support of a dues increase.

RECOMMENDATION:

1. That the proposal for a $30 per member dues increase effective January 1, 1995 be adopted.

2. That the remainder of the report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

10) REPORT OF THE BOARD OF DIRECTORS, ITEM #21, ADDITIONAL EMPLOYEE

The Board approved the addition of a seventh employee in the Association office. Subsequent to the addition of the sixth employee in 1977, the activity level of the Association has increased substantially. In 1977, the NMA had 1,518 members and there are now 1,878 members. The Association's budget in 1977 was $203,488 and the 1994 budget is $718,473 which directly reflects the increased activities by the Association's commissions, committees and other

organizational bodies. Testimony received acknowledges the fact that there has been significant increased activity of the Association resulting in an increased workload.

RECOMMENDATION:

1. That this item be approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House approved this section of the report.

(11) REPORT OF THE BOARD OF DIRECTORS, ITEM #25, TECHNICAL ADVISORY COMMITTEE

Testimony received indicated that there should be one medical policy advisory committee which could be made available to any insuring entity under a fee arrangement. There was support for expeditiously developing a technical advisory committee by the NMA.

RECOMMENDATION:

1. That this item be filed

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius rose in opposition to the "fee arrangement" language. He stressed the importance of keeping the lines of communication open with insurance companies and noted that only one request had been received to date. Dr. O'Leary emphasized the importance of the NMA establishing itself as a resource for this type of expertise as expeditiously as possible, including broad specialty representation. Dr. Helmick stated that during the Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems meeting, a representative from an insurance company had indicated that technical advice is sought and paid for across the country and they would rather pay for this advice locally. Dr. Cornelius differentiated between a technical advisory committee and a medical directors advisory committee and reiterated the importance of providing input. Dr. Paustian explained that the initial request from Blue Cross sought input from physicians in two areas: (1) Research activity and (2) Certain circumstances in medical care considered outliers. When this issue was discussed at the committee's meeting, the question of whether to market this service was raised. The consensus of the committee was that at the least, any expenses incurred by a physician serving in such a capacity should be reimbursed. Dr. Krynn Buckley stated that physicains are already being approached to serve in this capacity and that there is no shame in being paid for these services. The House then adopted this section of the report.

(12) REPORT OF THE BOARD OF DIRECTORS, ITEM #26, PRACTICE PARAMETERS

The Board received a recommendation from the PRO that the Association be involved in the review and consideration of various practice parameters as they are proposed. It was suggested that a specific committee be established for this purpose or that this could be assigned to the technical advisory committee. There appeared to be strong support for development of an NMA review panel for practice parameters to be established in the near future.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(13) REPORT OF THE BOARD OF DIRECTORS, ITEM #40, NOMINATIONS AND APPOINTMENTS

This item was received for information. The NMA encourages members who are interested in serving on state boards and committees to various groups inside and outside of state government to inform the executive director of the NMA of their willingness to serve.

RECOMMENDATION:

1. That this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(14) RESOLUTION #1 - HALL COUNTY MEDICAL SOCIETY - BYLAWS AMENDMENT TO ALLOW VA HOSPITAL PHYSICIANS TO JOIN ASSOCIATION WITHOUT VALID NEBRASKA LICENSE

Resolution #1 read as follows:

WHEREAS, the Association wishes to be broadly representative, and

WHEREAS, the Bylaws stipulate a current Nebraska state license, and

WHEREAS, practitioners at Veterans Administration Hospitals practice at these facilities by virtue of a valid license from any state;

THEREFORE, BE IT RESOLVED, that the Association extend an invitation to participate to these physicians, and

BE IT FURTHER RESOLVED, that the Bylaws be amended to permit physicians practicing at VA institutions within the State of Nebraska to join the Association by virtue of any valid state license to practice so long as their primary station remains within the state.

Currently, the Nebraska Medical Association bylaws require that a physician have an unrestricted license in order to be a member of the Association. Testimony was received concerning the long-term ramifications of permitting physicians who are not licensed in the State of Nebraska to belong to the Nebraska Medical Association. The testimony received was primarily opposed to amending the bylaws to permit physicians who are practicing at institutions within the State of Nebraska and who do not have a Nebraska license to become members of the NMA. It was pointed out that any physician who qualifies for and possesses a license to practice medicine and surgery in the State of Nebraska can be considered for membership in the NMA.

RECOMMENDATION:

1. That Resolution #1 not be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(16) RESOLUTION #6 - LANCASTER COUNTY MEDICAL SOCIETY - QUALITY ADVOCACY & RESOLUTION #12 - METRO OMAHA MEDICAL SOCIETY - NATIONAL COMMITTEE ON QUALITY ASSURANCE

Resolution #6 read as follows:

WHEREAS, quality, utilization and cost are leading issues as the health care system continues to change, and

WHEREAS, quality and cost effectiveness are key elements in services provided in health care plans, and

WHEREAS, those managing quality and cost effectiveness appropriately, will emerge as leaders in health care;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association educate their physician members regarding quality improvement including outcome, performance, process and other measures such as those developed by the National Committee on Quality Assurance (NCQA).

Resolution #12 read as follows:

WHEREAS, Managed Care Organizations are becoming a major influence in health care delivery, and

WHEREAS, a Managed Care Organization strives to be accredited by the National Committee on Quality Assurance (NCQA) in order to market their product to major employers, and

WHEREAS, NCQAs protocols and guidelines have a significant impact upon how a physician delivers care within his/her office;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association educate their members about NCQA requirements and how they will affect their office practice, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association direct the American Medical Association to continue to take a role in modifying and monitoring those NCQA protocols which impact upon a physician's practice.

Because of a similarity of the two resolutions, there was a general consensus that the two resolutions intent was best reflected in Resolution #12. The importance of educating the members of the NMA regarding quality improvement including outcome, performance, process and other measures was discussed. There was favorable testimony that this activity should be directed at the state level as well as at the national level. Currently, there are several organizations including the National Committee on Quality Assurance (NCQA), JCAHO, and HEDIS, and others, that are developing protocols and guidelines.

RECOMMENDATION:

1. That Resolution #6 not be adopted.

2. That Resolution #12 be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius suggested that rather than not adopting Resolution #6, the recommendation be worded to state "That Resolution #12 be adopted in lieu of Resolution #6". Dr. Dvorak agreed to this change. Question was raised as to whether this was proper parliamentary procedure. Dr. Cornelius, as Parliamentarian, stated that if resolutions are considered together, such treatment is permissible. The House then adopted this section of the report as amended.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #4 AS A WHOLE. This was adopted by the House.

I wish to thank Doctor Krynn Buckley and Doctor Susanne Eilts for serving on this reference committee and assisting in the preparation of this report.

Respectfully submitted,
Allen D. Dvorak, M.D., Chm., Omaha
Krynn K. Buckley, M.D., Lincoln
Susanne E. Eilts, M.D., Omaha

Reference Committee #5

Reference Committee #5 considered 10 reports and 5 resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #3, RESOLUTION #3, (A94) ANY WILLING PROVIDER LEGISLATION, RESOLUTION #10 (A94) WILLING PROVIDER AND PATIENT FREEDOM OF CHOICE, RESOLUTION #13 (A94) WILLING PROVIDERS.

Significant testimony was not heard in reference to this item.

RECOMMENDATION:

1. Your committee recommends that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(2) REPORT OF THE BOARD OF DIRECTORS, ITEM #7 (A94) COST OF SUBPOENAED RECORDS

No testimony was given in reference to this item.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(3) REPORT OF THE BOARD OF DIRECTORS, ITEM #23, COMMUNITY HEALTH SERVICES

No testimony was given in reference to this item.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The house adopted this secion of the report.

(4) REPORT OF THE BOARD OF DIRECTORS, ITEM #32, PHYSICIAN LICENSURE/DISCIPLINE

No testimony was given in reference to this item.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(5) REPORT OF THE BOARD OF DIRECTORS, ITEM #33, BLUE CROSS/BLUE SHIELD CLINICAL LAB POLICY

Information was given that this was forwarded to the Ad-Hoc Committee on Health Care Insurance and Medical Delivery Systems and the proposed policy is on hold.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(6) REPORT OF THE BOARD OF EXAMINERS IN MEDICINE & SURGERY

Testimony was heard from the Chairman, Philip S. Metz, M.D., and from his testimony we propose the following:

RECOMMENDATIONS:

1. That the NMA disseminate to the members the report by Mr. Doug Curry in the Nebraska Health Law Digest.

2. That the Report of the Board of Examiners in Medicine & Surgery be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF OUR REPORT. The House adopted this section of the report.

(7) REPORT OF THE STATE DEPARTMENT OF HEALTH

Lengthy testimony was heard in reference to this report. Dr. Mark Horton was in attendance and gave a well-detailed testimony. Also testimony was heard in reference to the VFC. Highlights of Dr. Horton's testimony included HIV reporting in reference to LB 819. Dr. Horton stated that the Health Department would be willing to work with the Association on further details in reference to this. The Uniform Licensure Law generated a considerable amount of discussion. It was revealed that Dr. Horton is asking for a moratorium in the 1995 session of the Legislature for any new bills dealing with licensure. This was felt by those members in attendance at the Reference Committee to be a well-conceived idea. A long discussion was again evoked in reference to the x-ray system operators and limited x-ray system operators in reference to the 1987 Radiation Control Act. Testimony was heard from the physician members that patients could suffer if x-rays are not available to those patients in their practices. Dr. Horton was optimistic that the resolution will come and that legislation will be introduced in the 1995 Session will help resolve this issue. He felt confident that we will "get there" in resolving this ongoing and frustrating problem. He made reference to the vaccines for children program. Testimony was received from pediatricians about their continued concerns of being able to administer vaccines in their offices rather than in heath clinics, and the problems presented to the patient who receives their vaccines from health clinics.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius asked whether Dr. Horton had explained the Department of Health's reasons for forcing the issue regarding limited x-ray system operators. Dr. Michels rose and spoke on behalf of the Nebraska Academy of Family Physicians and stated that the Academy was not as optimistic as Dr. Horton that this issue could be resolved and that the main reason that the Department of Health had forced the issue was to avoid a lawsuit threatened by the rad techs. Dr. Michels informed the House that the Academy planned to introduce legislation in the next session of the Unicameral to address this issue and asked for the NMA's support. Dr. Klutman informed the House that according to legal counsel, any citations or reports issued by the Department of Health could be appropriately filed and injunctions would be granted until this issue is resolved. Dr. Loschen stressed the importance of continuing dialogue with the Department of Health. The House then adopted this section of the report.

(8) REPORT OF THE COMMISSION ON LEGISLATION & GOVERNMENTAL AFFAIRS

No testimony was heard in reference to this report.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(9) REPORT OF THE NMA RADIATION SAFETY WORKING GROUP

Testimony was dovetailed into the testimony given on the Radiation Safety Act of 1987 in the Department of Health Report and again frustration was voiced by the physician members in attendance. No further light was shed on this problem at this point.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(10) REPORT OF THE AD-HOC COMMITTEE ON HEALTH CARE INSURANCE AND MEDICAL DELIVERY SYSTEMS

Testimony was not heard as to this report.

RECOMMENDATION:

1. We recommend that this item be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(11) RESOLUTION #5 - LANCASTER COUNTY MEDICAL SOCIETY - PATIENT PROTECTION ACT AND RESOLUTION #9 - METRO OMAHA MEDICAL SOCIETY - PATIENT FREEDOM OF CHOICE

Resolution #5 read as follows:

WHEREAS, the American Medical Association has placed a major emphasis on choice to accomplish a more cost-effective health care delivery system, and

WHEREAS, the American Medical Association believes that the ideal health care system maximizes opportunity for consumer choice in every area — choice of physician, choice of health plan and choice of medical treatment, and

WHEREAS, the American Medical Association has developed and introduced the "Patient Protection Act" into federal legislation;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association incorporate the principles and suitable language of the American Medical Association's Patient Protection Act into new state legislation that pertains to protection of consumer choice, certification of managed care plans and utilization review programs, choice requirements for point-of-service plans and choice of health plans for enrollment, and

BE IT FURTHER RESOLVED, that this legislation be introduced to the Nebraska Unicameral in the 1995 session.

Resolution #9 read as follows:

WHEREAS, several resolutions were presented to the Nebraska Medical Association's House of Delegates at the Spring 1994 meeting concerning Willing Provider Legislation, and

WHEREAS, the problems that led to those resolutions still exist;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association continue to work on reintroduction of Patient Freedom of Choice legislation in the 1995 Nebraska Unicameral, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association continue to find other organizations and patients who are willing to contact their state senators and testify at legislative hearings in favor of a "willing provider and patient freedom of choice" bill.

Testimony was heard in reference to Resolution #5, and Resolution #9. It was felt by the Reference Committee that the intent of Resolution #9 is the same as that of Resolution #5.

RECOMMENDATIONS:

1. We recommend that Resolution #5 be adopted.

2. We recommend that Resolution #9 not be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius suggested that the recommendation be changed to read "We recommend that Resolution #5 be adopted in lieu of Resolution #9". Dr. Reed agreed to this change and the House then adopted this section of the report as amended.

(12) RESOLUTION #10 - METRO OMAHA MEDICAL SOCIETY - PATIENT PROTECTION ACT

Resolution #10 read as follows:

WHEREAS, the American Medical Association has articulated strong policy positions on patient access to care and is calling for regulation of managed care plans to assure fairness to patients and providers, and

WHEREAS, the American Medical Association Patient Protection Act would require managed care plans to provide prospective enrollees/patients with information regarding plan terms and conditions of the plan to allow informed decisions about accepting a certain system of health care delivery, and

WHEREAS, the standards specifically must include requirements for information to be provided on: 1) coverage provisions and exclusions; 2) prior authorization or other review requirements; 3) financial arrangements that would limit the services offered, restrict referral options, and established incentives not to deliver certain services; 4) plan limitations and the impact of any limitations upon an enrollee; 5) loss ratios; and 6) enrollee satisfaction statistics, and

WHEREAS, plans would also be required to demonstrate that they have adequate access to physicians and other providers, and that they meet financial reserve requirements;

THEREFORE, BE IT RESOLVED, that the Legislative Committee of the Nebraska Medical Association review the American Medical Association's Patient Protection Act and incorporate it into any state legislation that pertains to managed health care plans.

Testimony was heard that in addition to the subject identified as the Patient Protection Act, it could also be known as the "truth in advertising" resolution. No further testimony was given. Only positive testimony was heard.

RECOMMENDATION:

1. We recommend that Resolution #10 be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and carried.

(13) RESOLUTION #11 - METRO OMAHA MEDICAL SOCIETY - QUALITY ASSURANCE

Resolution #11 read as follows:

WHEREAS, there are a growing number of patient care activities being performed at free standing facilities and at physician offices, and

WHEREAS, it is in the best interest of the community as a whole to maintain the highest possible quality of medical care;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association request the Nebraska State Legislature provide protection and safeguards to physicians performing quality assurance activities in their practices.

Discussion was heard from members of the Association in reference to Resolution #11. While the committee agreed somewhat with the intent of the resolution, it was felt it should be referred to the Board.

RECOMMENDATION:

1. Your Reference Committee recommends that

the resolution be forwarded to the Board of Directors for further consideration.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(14) RESOLUTION #15 - CHEYENNE-KIMBALL-DEUEL COUNTY MEDICAL SOCIETY - LIMITED X-RAY SYSTEM OPERATOR EDICT

Resolution #15 read as follows:

WHEREAS, the Nebraska Legislature mandated a course of instruction of 16 hours for limited x-ray system operators for public safety reasons, and

WHEREAS, the Nebraska Department of Health has determined that a course of 100 hours is necessary for this certification and has refused to approve any courses of 16 hours, and

WHEREAS, the Director of Health promised the NMA that the Department would not enforce the regulations until adequate courses of instruction were available at a reasonable cost but recently determined that two courses in Omaha and a $700 correspondence course in Scottsbluff constituted adequate courses of instruction for the entire state, and

WHEREAS, this edict represents another requirement that further reduces the attractiveness of medical practice in rural and frontier Nebraska towns and will further limit the public's access to diagnostic services;

THEREFORE, BE IT RESOLVED, that the NMA protest this unfair decision on the part of the Nebaska Department of Health which circumvents the intent of the Legislature, and

BE IT FURTHER RESOLVED, that the NMA support legislation which would require the Department of Health to cancel this most recent edict and to develop reasonable requirements for limited x-ray system operator courses of instruction and certification which meet the needs of Nebraska's citizens and not further limit access to diagnositc x-rays for persons in rural areas.

Discussion in reference to this was felt to be part of the continuing and ongoing discussion in reference to the limited x-ray system operator law. It was felt that this is a well-worded resolution.

RECOMMENDATION:

1. Your Reference Committee recommends the resolution be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #5 AS A WHOLE. This was adopted.

Respectfully submitted,
John L. Reed, M.D., Chm., Lincoln
Chris E. Wilkinson, M.D., Kearney
Peter J. Whitted, M.D., Omaha

I would like to express my appreciation to the members of Reference Committee #5 for their considerable help.

Reference Committee #6

Reference Committee #6 considered 10 reports and 1 resolution. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE BOARD OF DIRECTORS, ITEM #4, RESOLUTION #4 (A94) BREAST CANCER EDUCATION; REPORT OF THE BOARD OF DIRECTORS, ITEM #5, RESOLUTION #5 (A94) PHYSICIAN EDUCATION, BREAST CANCER; REPORT OF THE BOARD OF DIRECTORS, ITEM #30, HEALTH QUEST; REPORT OF THE BOARD OF DIRECTORS, ITEM #31, "EVERY WOMAN MATTERS" PROJECT; REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

Collectively, these items were very similar in nature and addressed the same scope of material and therefore were considered together. Your reference committee noted the activities of the Commission on Public Affairs which has addressed the breast cancer screening program, physician education on breast cancer, the Health Quest program at the Nebraska State Fair and the "Every Woman Matters" Project. No testimony was heard concerning these items.

RECOMMENDATION:

1. We recommend that the Report of the Board of Directors, Items #4, #5, #30, and #31 be filed.

2. We recommend that the Report of the Commission on Public Affairs be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(2) REPORT OF THE BOARD OF DIRECTORS, ITEM #11, RESOLUTION #14 (A94) PROHIBITION OF SMOKING IN PUBLIC PLACES

No discussion was heard concerning this report. The resolution calls on the Association to support any and all state and federal initiatives to ban smoking in public places with the emphasis being on health care facilities.

RECOMMENDATION:

1. We recommend that Item #11 of the Report of the Board of Directors concerning Resolution #14 (A94) prohibition of smoking in public places be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(3) REPORT OF THE BOARD OF DIRECTORS, ITEM #29, PREVENTIVE LAW SEMINAR

Testimony was heard from those who had attended the seminar. Comments were largely positive concerning the material presented. It is hoped that the Association will endorse similar seminars in the future.

RECOMMENDATION:

1. We recommend that the Report of the Board of Directors, Item #29, concerning the preventive law seminar be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SETION OF OUR REPORT. The House adopted this section of the report.

(4) REPORT OF THE AD-HOC COMMITTEE ON HEALTH EDUCATION

An addendum to the report of this committee was distributed to your reference committee. Discussion was received concerning the activities of this committee. Contact has been made with the Division Director of Health Promotions and other appropriate representatives of the Nebraska Department of Health to discuss how the two committees might work together for the purpose of enhancing health education in the schools of Nebraska. A publication from the American Medical Association entitled, "Culturally Competent Health Care for Adolescents: A Guide for Primary Care Providers", is available for purchase as an aid to health care curriculum. Copies of this publication are expected to be made available in the Association office for perusal by anyone interested. Discussion was also received concerning the definition of "consultant" to public schools. It is the Committee on Health Education's stand that this includes any person from the medical profession (or for that matter, other professionals) who give of their time voluntarily or perhaps on a paid basis to participate in health education in the schools. Many members of the Nebraska Medical Association have very willingly and graciously donated their time and talents along this line for many years. It is the feeling of this reference committee that such activity should definitely be encouraged and continued by the physicians of this state wherever possible.

RECOMMENDATION:

1. We recommend that the Report of the Ad-Hoc Committee on Health Education and its addendum be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(5) REPORT OF THE AD-HOC COMMITTEE ON LOW LEVEL RADIOACTIVE WASTE DISPOSAL

Brief discussion was heard concerning the activities of this committee. It was noted that in possible restructuring of the Nebraska Medical Association's committees that the activity of this particular committee might in fact be expanded. The reference committee feels very strongly that a panel of physicians knowledgeable on such subjects should definitely be active and continue to monitor this very important issue.

RECOMMENDATION:

1. Your Reference Committee recommends that the report of the Ad-Hoc Committee on Low Level Radioactive Waste Disposal be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This section of the report was adopted by the House.

(6) REPORT OF THE AD-HOC COMMITTEE ON MATERNAL AND CHILD HEALTH

Considerable discussion was heard concerning the activities of this committee. It was noted that at the present time, the Department of Health is deeply involved in an upgrade of their computer system which will better enable the retrieval of data. It was noted that the Bureau of Vital Statistics will need to be involved in the retrieval of such data so that confidentiality may be maintained. The primary purpose of this data is focused on education and in no way is meant to be used for sanctioning, or to be provided as any form of evidence. The committee is working in five year blocks. They are presently doing an in-depth study of fetal deaths. When this study is completed, it is the intention of the committee to do an in-depth neonatal survey. Cooperation from the physicians of the state has been excellent. The committee also intends to continue monitoring referral patterns from Level I hospitals to appropriate consulting facilities should the need arise. Your Reference Committee again wishes to commend Dr. Bausch and his group for their very fine work.

RECOMMENDATION:

1. Your Reference Committee recommends that this report be filed.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

(7) RESOLUTION #16 - GREATER NEBRASKA CAUCUS - NMA ENDORSEMENT OF THE COMMISSION ON OFFICE LABORATORY ACCREDITATION (COLA)

Resolution #16 read as follows:

WHEREAS, the Commission on Office Laboratory Accreditation (COLA) is the only non-profit education and accreditation organization for the physician office laboratory, and

WHEREAS, COLA was established by the American Medical Association, the American Academy of Family Physicians, the College of American Pathologists, and the American Society of Internal Medicine, and

WHEREAS, COLA is deemed by the Health Care Financing Administration (HCFA) to be an alternative to CLIA-88, and

WHEREAS, physicians with office laboratories can comply with CLIA-88 standards through COLA accreditation, and

WHEREAS, in most instances COLA accreditation will be less expensive for the office laboratories than CLIA certification through the state health department, and

WHEREAS, the COLA accreditation program includes an educational component for office laboratory personnel which assures that the data generated by COLA-approved laboratories is not only in compliance with CLIA standards, but also is of excellent quality, and

WHEREAS, the Nebraska Legislature has upheld a moratorium on the implementation of LB 551, the Nebraska Laboratory Accreditation bill, in favor of the implementation of CLIA-88 in Nebraska in lieu of Nebraska's own laboratory bill;

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association (NMA) endorse the accreditation for office laboratories of the Commission on Office Laboratory Accreditation, and

BE IT FURTHER RESOLVED, that the NMA publicize information about COLA and encourage all physicians who own or operate office laboratories to seek

accreditation through COLA as their private peer-reviewed alternative to CLIA and state licensure.

Testimony favorable to the adoption of this resolution was received. The COLA program is endorsed by the American Medical Association and the American Academy of Family Practice and is currently used by many office laboratories in the state.

RECOMMENDATION:

1. Your Reference Committee recommends that Resolution #16 be adopted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. The House adopted this section of the report.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #6 AS A WHOLE. This was adopted by the House.

I wish to thank Drs. Elvin Brown and Larry Ruth for their help on this committee.

Respectfully submitted,
Edward A. Holyoke, Jr., M.D., Chm., Omaha
Elvin G. Brown, M.D., Hastings
Larry D. Ruth, M.D., Lincoln

Dr. Cornelius expressed surprise at the dichotomous positions taken by the Department of Health, on the one hand pushing for independent practice for nurse practitioners and physician assistants and then on the other hand, saying that nurses are not qualified to take x-rays.

Dr. Meissner called for any unfinished business. Dr. Fosnaugh, on behalf of the Lancaster County Medical Society, nominated Dr. R. Michael Norris of Lincoln to attend the 1995 AMA Leadership Conference. The House was informed that, in addition to Dr. Norris, the President-Elect of the NMA and one staff person would also attend. The House then elected Dr. Norris as an NMA representative to the 1995 AMA Leadership Conference.

Dr. Klutman announced that Dr. Darroll Loschen of York had been named Family Physician of the Year by the Nebraska Academy of Family Physicians. Following Dr. Loschen's recognition, the House adjourned.

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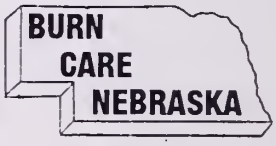

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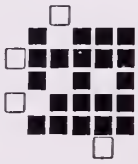

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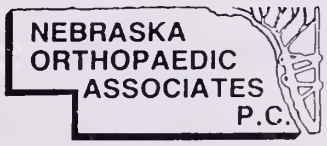

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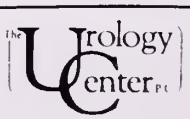

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CO-APPLICANT

Name	Address		Birth Date / /
City	State	Zip	Rent/House Payment $
Employer/Group	Address	Social Sec. # - -	
Bus. Phone ( )	Income $	No. of years	
Home Phone ( )	Other Income	Income from alimony, child support, or separate maintenance payments need not be revealed If you do not choose to have it considered as a basis for repaying this obligation $	

TRANSFER CURRENT ACCOUNT

I authorize FirsTier to transfer my current bank credit card balance

Account Number	Balance $	Payment Address
Account Number	Balance $	Payment Address

SIGNATURES

I warrant I am 19 years of age or older and subject to no legal disability, and that everything stated in this application is true and complete. FirsTier Bank is authorized to investigate the information, obtain my credit reports, answer inquiries about its credit experience with me and request additional information as necessary to process this application. My signature indicates agreement to terms and conditions accompanying the card and any renewal or replacement card.

Applicant Signature Date

Co-Applicant Signature Date

Annual Percentage Rate for Purchases	Today's rate would be 15.9% APR.
Variable Rate Information	The variable rate will be determined by the "Prime Rate" published in the Wall Street Journal on the second Tuesday of March, June, September and December. The credit card rate will be the "Prime" plus 8.4% with a minimum rate of 15.9% APR.
Grace Period for Payment of Purchases	You have 25 days from the billing cycle closing date to repay your balance in full before being charged a finance charge for current billing cycle purchases.

Method of Computing the Balance for Purchases	Two Cycle Average Daily Balance (excluding new purchases).
Annual Fee	$0
Late Fee, Overlimit Fee, and Returned Check Charge	1. Late Payment fee — 5% of the late payment with a $5.00 maximum. 2. Overlimit fee - $10.00 and 3. Returned check fee — $15.00

The information about the costs of the card described in this application is accurate as of February 1993, when it was printed. This information may change after the printing date. To find out what may have changed, call us at 1-800-432-3209. Or, write to us at FirsTier Bank Credit Card Center, P.O. Box 7, Omaha, NE 68101-0007.

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If you or your group is interested in our Nebraska Medical VISA Business Plan, call (402) 474-4472.

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